Case Mix Reviews Update …and Much More!

Agenda

Louisiana Nursing Home Association
and
Louisiana Department of Health and Hospitals
May 2005 Training

Case Mix Reviews Update
……and *Much More*!

9:00 to 9:30	**Registration**
9:30 to 10:00	**State Review Statistics and Case Mix MDS Items Most Frequently Unsupported**
10:00 to 10:30	**"Revised" Supportive Documentation Guidelines**
10:30 to 10:45	**BREAK**
10:45 to 12:00	**NEW Spiral Training Manual and *Much More***
12:00 to 1:00	**LUNCH**
1:00 to 2:00	**CMI Report and *Much More***
2:00 to 3:00	**ADLs and *Much More***
3:00 to 3:30	**Case Mix Reviews and *Much More***

Louisiana Nursing Home Association
And
Louisiana Department of Health and Hospitals
Case Mix Reviews Update…..and *Much More!*
May 2005
Evaluation

Instructions for completion: Please check or circle the response that most appropriately indicates your evaluation of the seminar and presentation.

Name (optional) _____

Facility (optional) _____

Did this training provide information on the areas that will help you?
_____ Completely _____ Partially _____ Not at All

The level and complexity of the training was?
_____ Too Advanced _____ About Right _____ Too Basic

4 = Excellent	3 = Good	2 = Fair	1 = Poor
Overall rating of the program:	4	3	2	1
Presenter	4	3	2	1
Objectives Met	4	3	2	1
Content Appropriate	4	3	2	1
Physical Environment Appropriate	4	3	2	1

Comments and Suggestions:

_____

_____

_____

_____

_____

Please complete and leave on the registration table. Thank you.

State Statistics

Louisiana Nursing Home Association and
Louisiana Department of Health and Hospitals
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Overall State Statistics Report

Facility Statistics		
Total Number of Facilities Subject to a Review	142	100%
Total Number/Percent of Facilities Reviewed	53	37%
Total Number/Percent of Facilities with Greater than 40% Unsupported	12	23%
Total Number/Percent of Facilities with 40% or Less Unsupported	41	77%
Assessment Reviewed Statistics		
Total Number/Percent of Assessments Subject to a Review	5,373	100%
Total Number/Percent of Assessments Reviewed	1,526	28%
Total Number/Percent of Assessments Unsupported	471	31%
Total Number/Percent of Assessments Supported	1,055	69%
Unsupported Percent by ADL and or Other		
Total Number/Percent of Unsupported Assessments	471	100%
Total Number/Percent of Unsupported Assessments Based on ADLs only	119	25%*
Total Number/Percent of Unsupported Assessments Based on Non-ADLs	135	29%**
Total Number/Percent of Unsupported Assessments Based on ADLs and Non-ADLs	217	46%***

* RUG-III classification changed due to unsupported ADLs only.
** RUG-III classification changed due to unsupported Non-ADLs only.
*** RUG-III classification changed due to unsupported ADLs and Non-ADL RUG-III Items.

Note: Data as of 3/11/2005

Louisiana Nursing Home Association and
Louisiana Department of Health and Hospitals
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RUG-III Classification Summary

	Number of Assessments			
	Pre Review			
RUG-III Class	Total	Unsupported	Percentage Unsupported	Post Review
Extensive Services	198	58	29%	167
Rehabilitation	275	69	25%	268
Special Care	274	85	31%	237
Clinically Complex	278	73	26%	285
Impaired Cognition	262	113	43%	219
Behavior Problems	94	31	33%	89
Reduced Physical Functions	145	42	29%	261
Total	1,526	471	31%	1,526

Most Frequently Unsupported MDS Items

Louisiana Nursing Home Association and Louisiana Department of Health and Hospitals May 2005 Training

RUG-III String Validation Sorted by Percent Unsupported

Item Location	Item Description	Frequency	Unsupported	Percentage Unsupported
P1b, H3, P3	3 Days, 45 Minutes OT, PT, ST; 2 + Nursing	35	21	60%
B1, N1a,b,c	Coma, Not Awake, Completely	2	1	50%
J1h, I2e	Fever and Pneumonia	4	2	50%
J1h, J1o	Fever and Vomiting	2	1	50%
B2a, B4, C4	Impaired Cognition	380	183	48%
I1a, O3, P8	Diabetes, Injections, Physician Order	32	15	47%
P7, P8	Physician Visits, Order Changes	71	32	45%
M4c, M5	Open Lesions and Skin	31	11	35%
K5b, K6b, I1r	Feeding Tube with High Calories, Fluids and Aphasia	3	1	33%
K5b, K6	Feeding Tube with High Calories and Fluids	10	3	30%
P1b	5 Days, 150 Minutes of OT, PT, ST	257	71	28%
M6b, M6f	Infection of Foot with Dressings	4	1	25%
K5b, K6, I1r	Feeding Tube with High Calories and Aphasia	53	9	17%
M6c, M6f	Open Foot Lesions with Dressings	18	3	17%
M2a, M5	Stage 3 or 4 Ulcer and Skin	73	10	14%
M4g, M5	Surgical Wounds and Skin	63	7	11%
M1, M5	Ulcers and Skin Treatments	62	2	3%
K5b, K6a	Feeding Tube with High Calories	177	1	1%
J1h, J1c	Fever and Dehydration	0	0	0%
J1h, K5b	Fever and Feeding Tube	5	0	0%
J1h, K3a	Fever and Weight Loss	2	0	0%

Louisiana Nursing Home Association and
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MDS Item by Item Review Statistics
Reviews Completed for January 31, 2005 through March 11, 2005

Summary Report of All Unsupported Items
Sorted by Item

Item	Item Name	January		February		March		Total		
		Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
B1	Comatose	0	0	0	1	0	1	0	2	0.0%
B2a	ST memory	0	6	55	224	45	144	100	374	26.7%
B4	Decision Making	3	7	65	235	54	150	122	392	31.1%
C4	Making Self Understood	4	7	38	128	46	102	88	237	37.1%
E1a	Negative statements (30)	0	0	1	6	1	1	2	7	28.6%
E1b	Repet questings(30)	1	1	2	6	1	2	4	9	44.4%
E1c	Repet verbalizations (30)	0	1	5	13	4	7	9	21	42.9%
E1d	Persistent anger (30)	1	3	5	21	3	10	9	34	26.5%
E1e	Self deprecation (30)	0	0	0	0	0	0	0	0	0.0%
E1f	Unrealistic fears (30)	0	0	4	6	1	2	5	8	62.5%
E1g	Recurrent statements (30)	0	0	3	5	0	0	3	5	60.0%
E1h	Repet health complaints	1	2	6	22	5	8	12	32	37.5%
E1i	Repet anxious complaints	2	3	4	21	7	11	13	35	37.1%
E1j	Unpleasant mood/AM (30)	1	3	5	13	0	2	6	18	33.3%
E1k	Insomnia/change pattern	0	2	4	8	1	3	5	13	38.5%
E1l	Sad/pained/worried facial	4	4	11	40	10	16	25	60	41.7%
E1m	Crying/tearfulness (30)	2	2	0	3	2	4	4	9	44.4%
E1n	Repetitive movements (30)	1	2	6	19	6	14	13	35	37.1%
E1o	Withdrawal/activities (30)	0	0	6	19	5	13	11	32	34.4%
E1p	Reduced social (30)	1	1	9	25	6	17	16	43	37.2%

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MDS Item by Item Review Statistics
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Summary Report of All Unsupported Items
Sorted by Item

		January		February		March		Total		
Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
E4aA	Wandering	1	1	3	6	1	2	5	9	55.6%
E4bA	Verbally abusive	2	3	0	7	3	4	5	14	35.7%
E4cA	Physically abusive	0	0	0	0	1	2	1	2	50.0%
E4dA	Socially inapprop	1	2	2	17	4	7	7	26	26.9%
E4eA	Resists Care	0	0	3	19	4	17	7	36	19.4%
G1aA	Bed mobility/SP	17	34	173	885	196	607	386	1,526	25.3%
G1aB	Bed mobility/S	15	34	113	885	137	607	265	1,526	17.4%
G1bA	Transfer/SP	17	34	186	885	210	607	413	1,526	27.1%
G1bB	Transfer/SP	17	34	103	885	145	607	265	1,526	17.4%
G1hA	Eating/SP	21	34	195	885	225	607	441	1,526	28.9%
G1iA	Toilet use/SP	22	34	227	885	245	607	494	1,526	32.4%
G1iB	Toilet use/SP	18	34	124	885	141	607	283	1,526	18.5%
H3a	Toileting plan (14)	4	4	20	24	6	15	30	43	69.8%
H3b	Bladder retrain prog (14)	0	0	0	0	2	3	2	3	66.7%
I1a	Diabetes	0	1	0	19	0	13	0	33	0.0%
I1r	Aphasia	0	0	13	44	2	17	15	61	24.6%
I1s	Cerebral palsy	0	2	0	14	0	5	0	21	0.0%
I1v	Hemiplegia	0	1	8	85	4	52	12	138	8.7%
I1w	Multiple sclerosis	0	0	1	9	0	3	1	12	8.3%
I1z	Quadriplegia	0	0	1	13	1	5	2	18	11.1%

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Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
I2e	Pneumonia	0	0	6	14	4	18	10	32	31.3%
I2g	Septicemia	0	0	4	8	2	2	6	10	60.0%
J1c	Dehydrated	1	1	2	4	1	1	4	6	66.7%
J1e	Delusions	2	3	3	17	5	11	10	31	32.3%
J1h	Fever	0	0	2	9	0	2	2	11	18.2%
J1i	Hallucinations	0	0	2	4	4	7	6	11	54.5%
J1j	Internal bleeding	0	0	3	5	3	4	6	9	66.7%
J1o	Vomiting	0	0	1	2	0	0	1	2	50.0%
K3a	Weight loss (30/180)	0	0	0	1	0	1	0	2	0.0%
K5a	Parenteral IV	1	1	27	77	18	33	46	111	41.4%
K5b	Feeding tube	0	1	2	115	0	77	2	193	1.0%
K6a	Total calories (%) recei	0	1	10	115	8	77	18	193	9.3%
K6b	Average fluid intake (daily)	0	0	1	4	1	6	2	10	20.0%
M1a	Ulcers: Stage 1	0	1	3	15	7	12	10	28	35.7%
M1b	Ulcers: Stage 2	1	4	18	58	23	51	42	113	37.2%
M1c	Ulcers: Stage 3	0	0	6	15	9	20	15	35	42.9%
M1d	Ulcers: Stage 4	0	0	5	25	5	18	10	43	23.3%
M2a	Pressure ulcer	0	1	4	39	5	35	9	75	12.0%
M4b	Burns	0	0	0	0	0	0	0	0	0.0%
M4c	Open lesions	0	3	0	10	2	19	2	32	6.3%

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		Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
M4g	Surgical wounds	0	2	1	42	1	22	2	66	3.0%
M5a	Press relieving device/c	2	2	22	27	24	25	48	54	88.9%
M5b	Pressure relieving devic	0	5	25	48	26	54	51	107	47.7%
M5c	Turn/reposition prog	3	3	51	59	47	53	101	115	87.8%
M5d	Nutrition/hydration inte	4	5	14	51	19	59	37	115	32.2%
M5e	Ulcer care	0	5	3	76	5	67	8	148	5.4%
M5f	Surgical wnd care	0	2	2	36	2	20	4	58	6.9%
M5g	App of dressings OTTF	1	6	5	94	16	85	22	185	11.9%
M5h	App of oint/med OTTF	0	7	8	91	12	79	20	177	11.3%
M6b	Infection of foot	0	0	0	2	1	2	1	4	25.0%
M6c	Open lesions/foot	0	0	1	14	1	4	2	18	11.1%
M6f	Foot dressings	0	0	1	15	2	6	3	21	14.3%
N1a	Time Awake: AM	0	0	0	1	0	1	0	2	0.0%
N1b	Time Awake: noon	0	0	0	1	0	1	0	2	0.0%
N1c	Time Awake: PM	0	0	0	1	0	1	0	2	0.0%
O3	Injections (# days)	0	1	3	19	4	13	7	33	21.2%
P1aa	Chemotherapy (14)	0	0	1	5	1	1	2	6	33.3%
P1ab	Dialysis (14)	0	0	1	14	0	6	1	20	5.0%
P1ac	IV med (14)	0	2	8	128	12	66	20	196	10.2%
P1ag	Oxygen therapy (14)	0	0	5	71	6	42	11	113	9.7%

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Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
P1ah	Radiation (14)	0	0	0	1	2	6	2	7	28.6%
P1ai	Suctioning (14)	0	0	2	9	1	7	3	16	18.8%
P1aj	Trach care (14)	0	0	0	8	1	7	1	15	6.7%
P1ak	Transfusions (14)	1	1	3	17	1	5	5	23	21.7%
P1al	Ventilator (14)	0	0	0	0	0	2	0	2	0.0%
P1baA	ST/days	0	1	2	46	6	49	8	96	8.3%
P1baB	ST/minutes	0	1	3	46	13	49	16	96	16.7%
P1bbA	OT/days	0	3	9	125	16	92	25	220	11.4%
P1bbB	OT/minutes	0	3	18	125	19	92	37	220	16.8%
P1bcA	PT/days	0	5	11	131	18	102	29	238	12.2%
P1bcB	PT/minutes	1	5	18	131	22	102	41	238	17.2%
P1bdA	RT/days	0	0	2	6	4	7	6	13	46.2%
P3a	NR/PROM	3	3	13	18	8	15	24	36	66.7%
P3b	NR/AROM	2	2	33	51	17	22	52	75	69.3%
P3c	NR/Splint or brace	2	2	5	7	2	2	9	11	81.8%
P3d	NR/Bed mobility	0	0	5	5	7	7	12	12	100.0%
P3e	NR/Transfer	1	1	11	18	11	12	23	31	74.2%
P3f	NR/Walking	1	1	10	25	5	11	16	37	43.2%
P3g	NR/Dressing	3	3	29	33	16	17	48	53	90.6%
P3h	NR/Eating	2	2	16	20	5	10	23	32	71.9%

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P3i	NR/Prosthesis care	0	0	0	0	0	0	0	0	0.0%
P3j	Communication	0	0	0	1	1	1	1	2	50.0%
P7	Physician Visits (14)	0	2	19	59	6	19	25	80	31.3%
P8	Physician Orders (14)	1	3	24	70	11	30	36	103	35.0%

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		Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
P3d	NR/Bed mobility	0	0	5	5	7	7	12	12	100.0%
P3g	NR/Dressing	3	3	29	33	16	17	48	53	90.6%
M5a	Press relieving device/c	2	2	22	27	24	25	48	54	88.9%
M5c	Turn/reposition prog	3	3	51	59	47	53	101	115	87.8%
P3c	NR/Splint or brace	2	2	5	7	2	2	9	11	81.8%
P3e	NR/Transfer	1	1	11	18	11	12	23	31	74.2%
P3h	NR/Eating	2	2	16	20	5	10	23	32	71.9%
H3a	Toileting plan (14)	4	4	20	24	6	15	30	43	69.8%
P3b	NR/AROM	2	2	33	51	17	22	52	75	69.3%
H3b	Bladder retrain prog (14)	0	0	0	0	2	3	2	3	66.7%
J1c	Dehydrated	1	1	2	4	1	1	4	6	66.7%
J1j	Internal bleeding	0	0	3	5	3	4	6	9	66.7%
P3a	NR/PROM	3	3	13	18	8	15	24	36	66.7%
E1f	Unrealistic fears (30)	0	0	4	6	1	2	5	8	62.5%
E1g	Recurrent statements (30)	0	0	3	5	0	0	3	5	60.0%
I2g	Septicemia	0	0	4	8	2	2	6	10	60.0%
E4aA	Wandering	1	1	3	6	1	2	5	9	55.6%
J1i	Hallucinations	0	0	2	4	4	7	6	11	54.5%
E4cA	Physically abusive	0	0	0	0	1	2	1	2	50.0%
J1o	Vomiting	0	0	1	2	0	0	1	2	50.0%

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Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
P3j	Communication	0	0	0	1	1	1	1	2	50.0%
M5b	Pressure relieving devic	0	5	25	48	26	54	51	107	47.7%
P1bdA	RT/days	0	0	2	6	4	7	6	13	46.2%
E1b	Repet questings(30)	1	1	2	6	1	2	4	9	44.4%
E1m	Crying/tearfulness (30)	2	2	0	3	2	4	4	9	44.4%
P3f	NR/Walking	1	1	10	25	5	11	16	37	43.2%
E1c	Repet verbalizations (30)	0	1	5	13	4	7	9	21	42.9%
M1c	Ulcers: Stage 3	0	0	6	15	9	20	15	35	42.9%
E1l	Sad/pained/worried facial	4	4	11	40	10	16	25	60	41.7%
K5a	Parenteral IV	1	1	27	77	18	33	46	111	41.4%
E1k	Insomnia/change pattern	0	2	4	8	1	3	5	13	38.5%
E1h	Repet health complaints	1	2	6	22	5	8	12	32	37.5%
E1p	Reduced social (30)	1	1	9	25	6	17	16	43	37.2%
M1b	Ulcers: Stage 2	1	4	18	58	23	51	42	113	37.2%
E1i	Repet anxious complaints	2	3	4	21	7	11	13	35	37.1%
E1n	Repetitive movements (30)	1	2	6	19	6	14	13	35	37.1%
C4	Making Self Understood	4	7	38	128	46	102	88	237	37.1%
E4bA	Verbally abusive	2	3	0	7	3	4	5	14	35.7%
M1a	Ulcers: Stage 1	0	1	3	15	7	12	10	28	35.7%
P8	Physician Orders (14)	1	3	24	70	11	30	36	103	35.0%

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Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
E1o	Withdrawal/activities (30)	0	0	6	19	5	13	11	32	34.4%
E1j	Unpleasant mood/AM (30)	1	3	5	13	0	2	6	18	33.3%
P1aa	Chemotherapy (14)	0	0	1	5	1	1	2	6	33.3%
G1iA	Toilet use/SP	22	34	227	885	245	607	494	1,526	32.4%
J1e	Delusions	2	3	3	17	5	11	10	31	32.3%
M5d	Nutrition/hydration inte	4	5	14	51	19	59	37	115	32.2%
I2e	Pneumonia	0	0	6	14	4	18	10	32	31.3%
P7	Physician Visits (14)	0	2	19	59	6	19	25	80	31.3%
B4	Decision Making	3	7	65	235	54	150	122	392	31.1%
G1hA	Eating/SP	21	34	195	885	225	607	441	1,526	28.9%
E1a	Negative statements (30)	0	0	1	6	1	1	2	7	28.6%
P1ah	Radiation (14)	0	0	0	1	2	6	2	7	28.6%
G1bA	Transfer/SP	17	34	186	885	210	607	413	1,526	27.1%
E4dA	Socially inapprop	1	2	2	17	4	7	7	26	26.9%
B2a	ST memory	0	6	55	224	45	144	100	374	26.7%
E1d	Persistent anger (30)	1	3	5	21	3	10	9	34	26.5%
G1aA	Bed mobility/SP	17	34	173	885	196	607	386	1,526	25.3%
M6b	Infection of foot	0	0	0	2	1	2	1	4	25.0%
I1r	Aphasia	0	0	13	44	2	17	15	61	24.6%
M1d	Ulcers: Stage 4	0	0	5	25	5	18	10	43	23.3%

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P1ak	Transfusions (14)	1	1	3	17	1	5	5	23	21.7%
O3	Injections (# days)	0	1	3	19	4	13	7	33	21.2%
K6b	Average fluid intake (daily)	0	0	1	4	1	6	2	10	20.0%
E4eA	Resists Care	0	0	3	19	4	17	7	36	19.4%
P1ai	Suctioning (14)	0	0	2	9	1	7	3	16	18.8%
G1iB	Toilet use/SP	18	34	124	885	141	607	283	1,526	18.5%
J1h	Fever	0	0	2	9	0	2	2	11	18.2%
G1aB	Bed mobility/S	15	34	113	885	137	607	265	1,526	17.4%
G1bB	Transfer/SP	17	34	103	885	145	607	265	1,526	17.4%
P1bcB	PT/minutes	1	5	18	131	22	102	41	238	17.2%
P1bbB	OT/minutes	0	3	18	125	19	92	37	220	16.8%
P1baB	ST/minutes	0	1	3	46	13	49	16	96	16.7%
M6f	Foot dressings	0	0	1	15	2	6	3	21	14.3%
P1bcA	PT/days	0	5	11	131	18	102	29	238	12.2%
M2a	Pressure ulcer	0	1	4	39	5	35	9	75	12.0%
M5g	App of dressings OTTF	1	6	5	94	16	85	22	185	11.9%
P1bbA	OT/days	0	3	9	125	16	92	25	220	11.4%
M5h	App of oint/med OTTF	0	7	8	91	12	79	20	177	11.3%
I1z	Quadriplegia	0	0	1	13	1	5	2	18	11.1%
M6c	Open lesions/foot	0	0	1	14	1	4	2	18	11.1%

Louisiana Nursing Home Association and
Louisiana Department of Health and Hospitals
May 2005 Training

MDS Item by Item Review Statistics
Reviews Completed for January 31, 2005 through March 11, 2005

Summary Report of All Unsupported Items
Sorted by Total Percent

		January		February		March		Total		
Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
P1ac	IV med (14)	0	2	8	128	12	66	20	196	10.2%
P1ag	Oxygen therapy (14)	0	0	5	71	6	42	11	113	9.7%
K6a	Total calories (%) recei	0	1	10	115	8	77	18	193	9.3%
I1v	Hemiplegia	0	1	8	85	4	52	12	138	8.7%
I1w	Multiple sclerosis	0	0	1	9	0	3	1	12	8.3%
P1baA	ST/days	0	1	2	46	6	49	8	96	8.3%
M5f	Surgical wnd care	0	2	2	36	2	20	4	58	6.9%
P1aj	Trach care (14)	0	0	0	8	1	7	1	15	6.7%
M4c	Open lesions	0	3	0	10	2	19	2	32	6.3%
M5e	Ulcer care	0	5	3	76	5	67	8	148	5.4%
P1ab	Dialysis (14)	0	0	1	14	0	6	1	20	5.0%
M4g	Surgical wounds	0	2	1	42	1	22	2	66	3.0%
K5b	Feeding tube	0	1	2	115	0	77	2	193	1.0%
B1	Comatose	0	0	0	1	0	1	0	2	0.0%
E1e	Self deprecation (30)	0	0	0	0	0	0	0	0	0.0%
I1a	Diabetes	0	1	0	19	0	13	0	33	0.0%
I1s	Cerebral palsy	0	2	0	14	0	5	0	21	0.0%
K3a	Weight loss (30/180)	0	0	0	1	0	1	0	2	0.0%
M4b	Burns	0	0	0	0	0	0	0	0	0.0%
N1a	Time Awake: AM	0	0	0	1	0	1	0	2	0.0%

Louisiana Nursing Home Association and
Louisiana Department of Health and Hospitals
May 2005 Training

MDS Item by Item Review Statistics
Reviews Completed for January 31, 2005 through March 11, 2005

Summary Report of All Unsupported Items
Sorted by Total Percent

		January		February		March		Total		
Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
N1b	Time Awake: noon	0	0	0	1	0	1	0	2	0.0%
N1c	Time Awake: PM	0	0	0	1	0	1	0	2	0.0%
P1al	Ventilator (14)	0	0	0	0	0	2	0	2	0.0%
P3i	NR/Prosthesis care	0	0	0	0	0	0	0	0	0.0%

Louisiana Nursing Home Association and Louisiana Department of Health and Hospitals May 2005 Training

Summary Report of the Number of Facility Issues Noted and Reported Following the Review

	Category	Number of Occurences	Facilities
1	A3a Date	1	1.9%
2	Impaired Cognition (B2a, B4 or C4)	41	77.4%
3	Sad Mood/Depression (E1)	22	41.5%
4	Behavior Problems (E4)	21	39.6%
5	ADL (G1)	50	94.3%
6	Scheduled Toileting/Programs (H3a/b only)	9	17.0%
7	Diagnosis (I1)	21	39.6%
8	TF Calories (K6a)	10	18.9%
9	Ulcer/Pressure Ulcer (M1 or M2a)	28	52.8%
10	Open Lesions/Surgical Wounds (M4c,g)	5	9.4%
11	Applications of Dressings/Ointments (M5g,h)	18	34.0%
12	Pressure Relieving Device (M5a,b)	31	58.5%
13	Turning and Repositioning Program (M5c)	34	64.2%
14	Nutrition/Hydration Intervention (M5d)	21	39.6%
15	MDS Items Requiring Administration Documentation O2, Suction, Trach Care (P1ag, P1ai, P1aj)	23	43.4%
16	Dialysis (P1ab)	0	0.0%
17	Licensed Therapy (P1b)	32	60.4%
18	Respiratory Therapy (P1bd)	3	5.7%
19	Nursing Restorative (P3)	21	39.6%
20	Physician Visit/Orders (P7/P8)	27	50.9%
21	Services with a Surgical Procedure	0	0.0%
22	Medical Records with Missing Dates	2	3.8%
23	Documentation from Hospital Stay	18	34.0%
24	Documentation Outside Period/Does not Exist/ Limited/Unable to Provide	38	71.7%

Number of Facilities Reviewed 53

Percent of Facilities who were Greater than 40% Unsupported 23%

Louisiana Nursing Home Association
And
Department of Health and Hospitals
Case Mix Review Issues and Findings
May 2005 Training

Following the facility review the RN will indicate issues and findings associated with the following categories. These areas are noted on the exit conference form by categories. Reviewed facilities will receive the narrative description that applies to the review findings on the summary 10-day letter.

____1-A3a Date
Documentation was routinely found dated after the end of observation date (A3a). Since the A3a date marks the end of observation, any documentation reported after the A3a date exceeds the window of supporting documentation requirement unless otherwise stated. The A3a date controls what care and services are captured on the MDS assessment. See pages 3-29 through 3-31 of the RAI manual.

____2-Impaired Cognition (B2a, B4 or C4)
Either examples and/or frequency specificity were not provided in the medical record to support cognition impairment (B2a, B4 or C4). Specific resident examples and frequency are required for short-term memory, decision-making, and making self-understood. See the MDS Supportive Documentation Guidelines.

____3-Sad Mood/Depression (E1)
Either examples and/or frequency specificity were not provided in the medical record to support depression, sad mood or anxiety. Specific resident examples and frequency are required for expressions of depression, sad mood or anxiety. See pages 3-60 through 3-64 of the RAI manual.

____4-Behavior Problems (E4)
Either examples and/or frequency specificity were not provided in the medical record to support behavior symptoms. Specific resident examples and frequency are required for expressions of behavior symptoms, hallucinations and delusions. See pages 3-66 through 3-68 and 3-139 of the RAI manual.

____5-ADL (G1)
The ADL supporting documentation during the observation period was either missing or inconsistent with the coding on the MDS. ADL responses on the MDS must reflect the resident's functionality during all shifts of the observation period. See pages 3-76 through 3-100 of the RAI manual.

____6-Scheduled Toileting/Programs (H3a/b only)
There was insufficient supporting documentation for a scheduled toileting plan or bladder retraining program. Documentation must include an organized, planned, documented, monitored and evaluated process. Documentation must also include resident's response to the program. Changing wet garments is not included in this concept. See pages 3-124 through 3-125 of the RAI manual and the Supportive Documentation Guidelines.

____7-Diagnosis (I1)
One or more active physician diagnosis was missing from the medical record or the diagnosis was not supported during the observation period. See pages 3-127 through 3-132 of the RAI manual.

____8-TF Calories (K6a)
The portion of total calories received by a resident through a feeding tube was not provided in the resident record. Calories are required to be reported as the percent of calories actually ingested in the last seven days. This requires documentation to report the calories required by the resident and the portion of total calories received through the tube feeding to support the percent of total calories ingested. See pages 3-155 through 3-156 of the RAI manual.

____9- Ulcer/Pressure Ulcer (M1 or M2b)
Ulcer staging was either not available or did not always support the MDS submission values. Pressure ulcers must be reverse staged on the MDS during the observation period. See pages 3-159 through 3-162 of the RAI manual.

____10-Open lesions/Surgical Wounds (M4c,g)
Supporting documentation was either insufficient or not available to verify the presence of an open lesion or surgical wound. See pages 3-165 through 3-166 of the RAI manual.

____11-Applications of Dressings/Ointments (M5g,h)
Evidence of any type of dressings or application of ointment was either insufficient or not available. See pages 3-167 through 3-168 of the RAI manual.

____12-Pressure Relieving Device (M5a,b)
One or more pressure relieving device(s) had insufficient supporting documentation in the medical record or was not recorded at least once during the observation period. Pressure reducing is not considered synonymous with pressure relieving. See pages 3-167 through 3-168 of the RAI manual.

____13 – Turning and repositioning program
There was insufficient supporting documentation for a turning and repositioning program. Documentation must include evidence of "a specific approach that is organized, planned, documented, monitored, and evaluated". Documentation should also include resident's response to the program. See pages 3-167 to 3-168 of the RAI manual and the MDS Supportive Documentation Guidelines.

____14-Nutrition/Hydration Intervention (M5d)
Nutrition or hydration intervention to manage skin problems is defined as dietary measures received by the resident for the purpose of preventing or treating specific skin conditions and must be stated as such in the medical record. See pages 3-167 through 3-168 of the RAI manual.

____15-MDS Items Requiring Administration Documentation/O2, Suction, Trach Care (P1ag, P1ai, P1aj)
One or more MDS items were coded on the MDS without supporting documentation to verify the administration of the item coded. Examples include but are not limited to suctioning, oxygen administration and tracheostomy care. See the MDS Supportive Documentation Guidelines.

____16-Dialysis (P1ab)
IV's, IV medications, and blood transfusions in conjunction with dialysis should not be coded under their respective MDS items. Documentation must include evidence that the procedure occurred during the observation period. See page 3-182 of the RAI manual.

____17-Licensed Therapy (P1b)
The licensed therapy days or minutes were not calculated correctly as reported on the MDS, or the supporting documentation did not match the reported values. Licensed therapy is defined as direct therapy services provided to the resident during the observation period. This does not include the initial evaluation time. See pages 3-185 through 3-189 of the RAI manual.

____18-Respiratory Therapy (P1bd)
The licensed respiratory therapy days or minutes was not calculated correctly as reported on the MDS, or the supporting documentation did not support the reported values or no supporting values were provided. Licensed respiratory therapy is defined as direct therapy services provided to the resident. This does not include the initial evaluation time. See pages 3-185 through 3-189 of the RAI manual.

____19-Nursing Restorative (P3)
The nursing restorative days reported on the MDS were not supported in the medical record and/or the five criterions defining a nursing restorative program had one or more components missing. See pages 3-191 through 3-195 of the RAI manual.

____20-Physician Visit/Orders (P7/P8)
Physician Visits and/or Physician Orders are required to be submitted on the MDS as the number of **days** of visits and orders received**,** not number of visits and orders. See pages 3-204 through 3-206 of the RAI manual.

____21-Services with a Surgical Procedure
One or more services were coded on the MDS that were provided solely in conjunction with a surgical procedure such as IV, medications or ventilators. Surgical procedures include routine pre and post-operative procedures. See page 3-184 of the RAI manual.

____22-Medical Records with Missing Dates
Supporting documentation identified in the medical record was not dated and therefore not sufficient to support one or more MDS elements reviewed during the review process. Documentation necessary to support MDS elements during the review process must be dated during the observation period.

____23-Documentation from Hospital Stay
One or more MDS elements coded on the MDS reflect events that occurred in the hospital and lacked supporting documentation from the hospital stay during the observation period. Supporting documentation is required to verify MDS elements coded as a result of the residents hospital stay.

____24-Documentation outside period/doesn't exist/limited/unable to provide
Supporting documentation was either outside the observation period, was not available, was limited or the facility was unable to provide supporting documentation when requested. Documentation must be provided during the review process in order to fully disclose the extent of documentation necessary to verify the RUG-III classification for the assessment.

“Revised” Supportive Documentation Guidelines

Louisiana Department of Health and Hospitals
Case Mix Supportive Documentation Guidelines
RUG-III, Version 5.12, 34 Grouper

Effective with assessments dated (A3a) on or after 6/15/2005
Version 4, 5/1/2005

Special Notes About Documentation

1) Information contained in the clinical record must be consistent and cannot be in conflict with the MDS. Inconsistencies will be deemed unsupported.

2) The entire medical record is subject to review.

3) Standard Medical Record Documentation Requirements
- Each page or individual document in the medical record must contain the resident's identification information. At a minimum, each page must include resident's name and complete date (mm/dd/yyyy).
- Initials and signatures rules
    - Supportive documentation entries must be dated and their authors identified by a signature or initial
    - Initials may never substitute when a full signature is required by law
    - When initials are used to identify the author, there must be a corresponding full signature to authenticate the initial
    - Full signatures should include first initial or name, last name and title/credential
    - Supportive documentation forms or tools that include entries completed by multiple staff members at different times must include dates and signatures or initials on the form or tool itself to clearly identify who completed each entry
    - When electronic signatures are used, there must be policies to identify those who are authorized to sign electronically and have safeguards in place to prevent unauthorized use of electronic signatures

Special Case Mix Review Information

1) State Corrective Action Phase-In (ReRug all unsupported assessments when facility exceeds State threshold)
    a. July 2004 – June 2005 — Greater than 40% Unsupported
    b. July 2005 – June 2006 — Greater than 35% Unsupported
    c. July 2006 – June 2007 and beyond — Greater than 25% Unsupported

2) Case mix assessment sample is equal to:
    a. Primary sample 20% (minimum of 10 assessments) of the current Final CMI Report
    b. Expanded sample 20% (minimum of 10 assessments) of the current Final CMI Report (required if primary sample is greater than 25% unsupported)

3) Any assessment with an R2b date greater than 121 days from the previous R2b date will be deemed delinquent and will be assigned a RUG-III code of BC1, denoting delinquency.

Louisiana Department of Health and Hospitals
Case Mix Supportive Documentation Guidelines
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Version 4, 5/1/2005

Element Listing of MDS RUG-III Items			
MDS 2.0 LOCATION	***FIELD DESCRIPTION***	***CASE MIX DOCUMENTATION GUIDELINES***	***MINIMUM DOCUMENTATION STANDARDS***
B1 (page 3-42 to 3-43)	Comatose ***(7-day look back)***	Must have a documented neurological diagnosis of coma or persistent vegetative state from physician.	*Requires active Dx of coma or persistent vegetative state, signed by the physician within the past 15 months.*
B2a (page 3-43 to 3-45)	Short-Term Memory ***(7-day look back)***	Short-term memory loss must be supported in the body of the medical chart with specific examples of the loss. (E.g., can't describe breakfast meal or an activity just completed). If there is no positive indication of memory ability, documentation must be cited in the medical record. Identify the most representative level of function, not the highest.	*Example(s) demonstrating short-term memory for this specific resident. One good example(s) within the observation period.*
B4 (page 3-46 to 3-47)	Cognitive Skills for Daily Decision Making ***(7-day look back)***	Evidence by example must be found in the medical chart of the resident's ability to actively make everyday decisions about tasks or activities of daily living, and not whether staff believes the resident might be capable of doing so. The intent of this item is to record what the resident is doing (performance).	*Example(s) demonstrating degree of compromised daily decision making. Code reflects impairment level. One good example(s) within the observation period.*
C4 (page 3-54)	Making Self Understood ***(7-day look back)***	Evidence by example of the resident's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these.	*Example(s) demonstrating resident's degree of ability to make self-understood. Code reflects impairment level. One good example(s) within the observation period.*
E1a-p (page 3-61 to 3-63)	Indicators of Depression, Anxiety, Sad Mood (Coded 1 or 2) ***(30-day look back)***	Examples of verbal and/or non-verbal expressions of distress i.e., depression, anxiety, and sad mood must be found in the medical chart irrespective of the cause. See MDS (E1) for specific details. Code (1) exhibited at least once during the last 30 days but less than 6 days a wk. Code (2) exhibited 6-7 days a wk. Frequency may be determined by either a tracking tool or log, or by specific narrative notes. If using narrative notes, would require a note for each incident.	*Example(s) demonstrating resident's specific sad mood, anxiety or depression indicator(s) must occur and be documented within the observation period. Frequency required within the 30-day period ending with the A3a date.*

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MDS 2.0 LOCATION	*FIELD DESCRIPTION*	*CASE MIX DOCUMENTATION GUIDELINES*	*MINIMUM DOCUMENTATION STANDARDS*
E4a-e Col.A only (page 3-66 to 3-68)	Behavioral Symptoms (Coded 2 or 3) ***(7-day look back)***	Examples of the resident's behavior symptom patterns that cause distress to the resident, or are distressing or disruptive to facility residents or staff members. Code (2) exhibited 4-6 days, but not daily Code (3) exhibited daily or more frequently i.e. multiple times each day Frequency may be determined by either a tracking tool or log, or by specific narrative notes. If using narrative notes, would require a note for each incident.	*Example(s) demonstrating resident's specific behavior symptoms must occur and be documented within the observation period. Frequency of behavior required within the 7-day period ending with the A3a date.*
G1a,b,i Col. A,B and G1h,A **(page 3-76 to 3-100)**	Physical Functioning and Structural Problems ADLs ***(7-day look back)***	These four ADLs include bed mobility, transfer, toileting, and eating and must be documented for the full observation period in the medical chart for purposes of supporting the MDS responses. Consider the resident's self-performance and support provided during all shifts, as functionality may vary.	*Documentation requires 24 hours/7 days within the observation period while in the facility. Must have signatures and dates to authenticate the services provided.* *If using an ADL grid, key for self-performance and support provided must be equivalent to the MDS key.*
H3a NURSING RESTORE SCORE ONLY (page 3-124 to 3-125)	Any Scheduled Toileting Plan ***(14-day look back)***	Evidence in the medical chart must support a plan whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet. Includes habit training and/or prompted voiding. Changing wet garments is not included in this concept. A "program" refers to a specific approach that is organized, planned, documented, monitored, and evaluated." Documentation must include an evaluation of the resident's response to the toileting program.	*Requires 1) Program must be care planned 2) evidence that toileting (plan) occurred within the observation period and 3) documentation describing an evaluation of the resident's response to the program. The resident's response must be noted within the observation period.*
H3b NURSING RESTORE SCORE ONLY (page 3-124 to 3-125)	Bladder Retraining Program ***(14-day look back)***	Evidence in the medical chart must support a retraining program where the resident is taught to delay urinating or resist the urgency to void. Residents are encouraged to void on a schedule rather than according to their urge to void. Documentation must include an evaluation of the resident's response to the retraining program.	*Requires 1) Program must be care planned 2) evidence that a retraining program occurred within the observation period and 3) documentation describing and evaluation of the resident's response to the program. The resident's response must be noted within the observation period.*

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MDS 2.0 LOCATION	*FIELD DESCRIPTION*	*CASE MIX DOCUMENTATION GUIDELINES*	*MINIMUM DOCUMENTATION STANDARDS*
I1a (page 3-127)	Diabetes Mellitus ***(7-day look back)***	In order to code the MDS, an active physician diagnosis must be present in the medical chart. Includes insulin-dependent and diet-controlled.	*Active Dx. signed by the physician within the past 15 months.*
I1r (page 3-128)	Aphasia ***(7-day look back)***	In order to code the MDS, an active physician diagnosis must be present in the medical chart. Aphasia is defined as a speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts, or understanding spoken or written language. Include aphasia due to CVA.This difficulty must be cited in the medical chart.	*Active Dx. signed by the physician within the past 15 months.*
I1s (page 3-128)	Cerebral Palsy ***(7-day look back)***	In order to code the MDS, an active physician diagnosis must be present in the medical chart with evidence of paralysis related to developmental brain defects or birth trauma. Includes spastic quadriplegia **secondary** to cerebral palsy.	*Active Dx. signed by the physician within the past 15 months.*
I1v (page 3-129)	Hemiplegia/ Hemiparesis ***(7-day look back)***	In order to code the MDS, an active physician diagnosis must be present in the medical chart. Paralysis/partial paralysis of both limbs on one side of the body. Left or right-sided paralysis is acceptable as a diagnosis.	*Active Dx. signed by the physician within the past 15 months. Left or right -sided weakness not included.*
I1w (page 3-129)	Multiple Sclerosis ***(7-day look back)***	In order to code the MDS, an active physician diagnosis must be present in the medical chart. Chronic disease affecting the CNS with remissions and relapses of weakness, incoordination, paresthesis, speech disturbances and visual disturbances.	*Active Dx. signed by the physician within the past 15 months.*
I1z (page 3-129)	Quadriplegia ***(7-day look back)***	In order to code the MDS, an active physician diagnosis must be present in the medical chart. Paralysis of all four limbs must be cited in the medical record. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury.	*Active Dx. signed by the physician within the past 15 months. Quadriparesis is not acceptable. Spastic Quad secondary to CP may not be coded as Quadriplegia. Quadriplegia secondary to severe organic syndrome of Alzheimer's type is **not** acceptable.*

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MDS 2.0 LOCATION	*FIELD DESCRIPTION*	*CASE MIX DOCUMENTATION GUIDELINES*	*MINIMUM DOCUMENTATION STANDARDS*
I2e (page 3-135 to 3-137)	Pneumonia ***(7-day look back)***	In order to code the MDS, an active physician diagnosis must be present in the medical chart. An inflammation of the lungs. Often there is a chest x-ray, medication order and notation of fever and symptoms.	*Active Dx. signed by the physician. A hospital discharge note referencing pneumonia during hospitalization is not sufficient unless current within the observation period.*
I2g (page 3-135 to 3-137)	Septicemia ***(7-day look back)***	In order to code the MDS, an active physician diagnosis must be present in the medical chart and may be coded when blood cultures have been drawn but "results" are not yet confirmed. Septicemia is a morbid condition associated with bacterial growth in the blood. Urosepsis is not considered for MDS review verification.	*Active Dx. signed by the physician. A hospital discharge note referencing septicemia during hospitalization is not sufficient unless current within the observation period.*
J1c (page 3-138 to 3-140)	Dehydrated; output exceeds intake ***(7-day look back)***	Supporting documentation must include 2 or more of the following: 1) Takes in less than 1500 cc of fluid daily 2) One or more clinical signs of dehydration, included but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, abnormal lab values, etc. 3) Fluid loss that exceeds intake daily A diagnosis of dehydration is **not** sufficient.	*Intake and Output records. Documented signs of dehydration. Must include 2 or more of the 3 dehydration indicators. A hospital discharge note referencing dehydration during hospitalization is not sufficient unless 2 of the 3 dehydration indicators are present within the observation period.*
J1e (page 3-139)	Delusions ***(7-day look back)***	Evidence in the medical chart must describe examples of resident's fixed, false beliefs not shared by others even when there is obvious proof or evidence to the contrary.	*Resident specific example(s) demonstrating at least one episode of delusion(s) within the observation period.*
J1h (page 3-139)	Fever ***(7-day look back)***	Recorded temperature 2.4 degrees greater than the baseline temperature. The route (rectal, oral, etc.) of temperature measurement must be consistent between the baseline and the elevated temperature.	*Must be able to calculate baseline unless the temp is above 101 degrees.*
J1i (page 3-139)	Hallucinations ***(7-day look back)***	Evidence in the medical chart that describes examples of resident's auditory, visual, tactile, olfactory or gustatory false sensory perceptions that occur in the absence of any real stimuli.	*Resident specific example(s) demonstrating at least one episode of hallucination(s) within the observation period.*

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MDS 2.0 LOCATION	*FIELD DESCRIPTION*	*CASE MIX DOCUMENTATION GUIDELINES*	*MINIMUM DOCUMENTATION STANDARDS*
J1j (page 3-139)	Internal Bleeding ***(7-day look back)***	Clinical evidence of frank or occult blood must be cited in the medical chart such as: black, tarry stools; vomiting "coffee grounds"; hematuria; hemoptysis; or severe epistaxis. Nosebleeds that are easily controlled should not be coded as internal bleeding.	*Does not include UA with positive RBC's, unless there is additional supporting documentation such as physician's note, nurses notes "observed bright red blood" etc.*
J1o (page 3-140)	Vomiting ***(7-day look back)***	Documented evidence of regurgitation of stomach contents; may be caused by any etiology.	*Documented evidence of regurgitation of stomach contents.*
K3a (page 3-150 to 3-152)	Weight Loss ***(30 and 180-day look back)***	Documented evidence in the medical chart of the resident's weight loss. 5% or more in last 30 days OR 10% or more in last 180 days	*The first step in calculating weight loss is to obtain the actual weights for the 30-day and 180-day time periods from the clinical record. Calculate percentage based on the actual weight. Do not round the weight.*
K5a (page 3-153 to 3-154)	Parenteral / IV ***(7-day look back)***	Include only fluids administered for nutrition or hydration such as: • IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently • IV fluids running at KVO (Keep Vein Open) • IV fluids administered via heparin locks Do **NOT** include: • IV medications • IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay • IV fluids administered solely as flushes • Parenteral/IV fluids administered during chemotherapy or dialysis • IV fluids used to reconstitute medications for IV administration (unless administered for nutrition or hydration)	*Administration records must be available within the observation period. If administration outside of facility, must provide hospital administration record. or other evidence of administration. Must provide evidence of fluid being administered for nutrition or hydration.*

MDS 2.0 LOCATION	*FIELD DESCRIPTION*	*CASE MIX DOCUMENTATION GUIDELINES*	*MINIMUM DOCUMENTATION STANDARDS*
K5b (page 3-153 to 3-154)	Feeding Tube ***(7-day look back)***	Documented evidence of a feeding tube that can deliver food/ nutritional substances/ fluids/medications directly into the gastrointestinal system.	*Evidence of feeding tube delivering nutrition within the observation period.*
K6a (page 3-154 to 3-156)	Calorie Intake ***(7-day look back)***	Documentation supports evidence of the proportion of all calories ingested (actually received) during the last seven days by IV or tube feeding that the resident actually received. This does not include calories taken p.o.	*Must know resident's calorie requirement to determine what % is received by feeding tube or IV. If resident is on a p.o. diet also, must document the % total calories that the tube provided within the observation period.*
K6b (page 3-156 to 3-158)	Average Fluid Intake ***(7-day look back)***	Actual average amount of fluid by IV or tube feeding the resident received during the last seven days. IV flushes are not included in this calculation. The amount of fluid in an IV piggyback is included in the calculation.	*Must be able to calculate average amount of fluid (cc) within the observation period.*
M1a-d (page 3-159 to 3-161)	Ulcers/Staging ***(7-day look back)***	Evidence of the number of skin ulcers at each stage, on any part of the body. For the MDS assessment, staging of ulcers should be coded in terms of what is seen (i.e., visible tissue) during the look back period. For example, a healing Stage 3 pressure ulcer that has the appearance (i.e., presence of granulation tissue, size, depth, and color) of a Stage 2 pressure ulcer must be coded as a "2" for purposes of the MDS assessment. Skin ulcers that develop because of circulatory problems, or pressure are coded in item M1. Rashes without open areas, burns, desensitized skin ulcers related to diseases such as syphilis and cancer and surgical wounds are **not** coded here, but are included in Item M4. Skin tears/shears are **not** coded here (M1) unless pressure was a contributing factor. • If an ulcer met the definition for more than one stage during the observation period, code the ulcer as it appeared in the time frame closest to the ARD • If a skin ulcer is repaired with a flap graft, it should be coded as a surgical wound and not as a skin ulcer. If the graft fails, continues to code it as a surgical wound until healed	*Skin ulcers must be coded in terms of what is seen within the look back period. Documentation must include staging of any type of skin ulcer within the observation period. If scab meets M1 definition of "ulcer", stage as "2" in M1.*

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MDS 2.0 LOCATION	*FIELD DESCRIPTION*	*CASE MIX DOCUMENTATION GUIDELINES*	*MINIMUM DOCUMENTATION STANDARDS*
M2a (page 3-161 to 3-164)	Pressure Ulcer ***(7-day look back)***	Includes any skin ulcer caused by pressure resulting in damage of underlying tissues. Record the highest stage caused by pressure resulting in damage of underlying tissues. Pressure ulcers must be coded in terms of what is seen during the look back period.	*Documentation must include pressure as cause of skin ulcer. Documentation must include staging of pressure ulcers in terms of what is seen (i.e. visible tissue) within the 7-day observation period.*
M4b (page 3-165)	Burns ***(7-day look back)***	Includes burns from any cause (e.g., heat, chemicals) in any stage of healing. This category does not include first-degree burns (changes in skin color only).	*Documentation must support evidence of second or third degree burns within the observation period.*
M4c (page 3-165)	Open Lesions/Sores ***(7-day look back)***	Skin lesions must be documented in the medical chart. Code in M4c any skin lesions that are not coded elsewhere in Section M. Include skin ulcers that developed as a result of diseases and conditions such as syphilis and cancer. Documentation must include a description of what is seen within the observation period. Do not code skin tears or cuts here.	*Documentation must include a description of what is seen within the observation period.*
M4g (page 3-166)	Surgical Wounds ***(7-day look back)***	Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. Documentation might include appearance, measurement, treatment, color, odor, etc. Does not include healed surgical sites or stomas**,** or lacerations that require suturing or butterfly closure as surgical wounds. • Do not code a debrided skin ulcer as a surgical wound. • If a skin ulcer is repaired with a flap graft, it should be coded as a surgical wound and not as a skin ulcer. If the graft fails, continues to code it as a surgical wound until healed.	*PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds*.
M5a (page 3-167 to 3-168)	Pressure Relieving Device/chair ***(7-day look back)***	Includes gel, air, or other cushioning placed on a chair or wheelchair. Include pressure relieving, pressure reducing, and pressure redistributing devices. Do not include egg crate cushions.	*Evidence proving pressure relieving, pressure reducing, and pressure redistributing devices. Documentation at least once within the observation period.*

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MDS 2.0 LOCATION	*FIELD DESCRIPTION*	*CASE MIX DOCUMENTATION GUIDELINES*	*MINIMUM DOCUMENTATION STANDARDS*
M5b (page 3-167 to 3-168)	Pressure Relieving Device/bed ***(7-day look back)***	Includes air fluidized, low air loss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Do not include egg crate mattress.	*Evidence proving pressure relieving, pressure reducing, and pressure redistributing devices. Documentation at least once within the observation period.*
M5c (page 3-167 to 3-168)	Turning/repositioning program ***(7-day look back)***	Evidence of continuous, consistent program for changing the resident's position and realigning the body. "Program" is defined as "a specific approach that is organized, planned, documented, monitored, and evaluated".	*Requires that 1) Program must be care planned 2) recorded daily within the observation period and 3) documentation describing an evaluation of the resident's response to the program. The resident's response must be noted within the observation period.*
M5d (page 3-167 to 3-168)	Nutrition/hydration intervention to manage skin problems ***(7-day look back)***	Evidence of dietary intervention received by the resident for the purpose of preventing or treating specific skin conditions. Vitamins and minerals, such as Vit. C or Zinc, which are used to manage a potential or active skin problem, should be coded here.	*Intervention(s) to manage skin problems must be specified and **purpose stated** (i.e., to promote wound healing, to manage skin problems, etc.) at least once within the observation period.*
M5e (page 3-167 to 3-168)	Ulcer Care ***(7-day look back)***	Includes any intervention for treating skin problems coded in M1, M2, and M4c. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.	*Treatment (care) must be recorded at least once within the observation period.*
M5f (page 3-167 to 3-168)	Surgical Wound Care ***(7-day look back)***	Includes any intervention for treating or protecting any type of surgical wound. Evidence of wound care must be documented in the medical chart.	*Treatment (care) must be recorded at least once within the observation period.*
M5g (page 3-167 to 3-168)	Application of dressings; other than to feet ***(7-day look back)***	Evidence of any type of dressing application (with or without topical medications) to the body.	*Treatment (care) must be recorded at least once within the observation period.*
M5h (page 3-167 to 3-168)	Application of ointments/medications (other than to feet) ***(7-day look back)***	Evidence includes ointments or medications used to treat a skin condition. This item does not include ointments used to treat non-skin conditions (e.g., nitropaste).	*Treatment (care) must be recorded at least once within the observation period.*
M6b (page 3-168 to 3-169)	Infection of the foot ***(7-day look back)***	Clinical evidence noted in the medical chart to indicate signs and symptoms of infection of the foot. Ankle problems are not considered foot problems and should not be coded in M6.	*Signs and symptoms must be recorded at least once within the observation period.*

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MDS 2.0 LOCATION	*FIELD DESCRIPTION*	*CASE MIX DOCUMENTATION GUIDELINES*	*MINIMUM DOCUMENTATION STANDARDS*
M6c (page 3-168 to 3-169)	Open lesion on the foot ***(7-day look back)***	Evidence of cuts, ulcers, or fissures.	*Cuts, ulcers or fissures must be recorded at least once within the observation period.*
M6f (page 3-168 to 3-169)	Applications of Dressings (feet) ***(7-day look back)***	Evidence of dressing changes to the feet (with or without topical medication) must be documented in the medical chart.	*Treatment (care) must be recorded at least once within the observation period.*
N1a,b,c (page 3-170 to 3-171)	Time Awake ***(7-day look back)***	Evidence of time awake or nap frequency should be cited in the medical chart to validate the answer. (No more than a total of a one-hour nap during any such period)	*Flow charts are not expected for information such as sleep and awake times.*
O3 (page 3-178 to 3-179)	Injections ***(7-day look back)***	Evidence includes the number of days during the seven-day observation period that the resident received any medication by subcutaneous, intramuscular, intradermal injection, antigen or vaccines. This does not include IV fluids or IV medications. For subcutaneous pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump.	*TB and flu injections included Do not count Vitamin B12 injections if given outside of observation period.*
P1 (page 3-182, 3-184)	Special Treatments, Procedures and Programs ***(14-day look back)***	Do not code services that were provided solely in conjunction with a surgical or diagnostic procedure and the immediate post-operative or post procedure recovery period. Surgical procedures include routine pre- and post-operative procedures.	
P1a,a (page 3-182)	Chemotherapy ***(14-day look back)***	Includes any type of chemotherapy (anticancer drug) given by any route for the sole purpose of cancer treatment. Evidence must be cited in the medical chart.	*If administered outside of facility, evidence of administration record must be provided within the observation period.*
P1a,b (page 3-182)	Dialysis ***(14-day look back)***	Includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility. Evidence must be cited in the medical chart.	*Documentation must include evidence that procedure occurred within the observation period.*
P1a,c (page 3-182)	IV Medication ***(14-day look back)***	Documentation of IV medication push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication. Do not include IV medications provided during chemotherapy or dialysis. Includes IV medications dissolved in a diluent as well as IV push medications. IV meds administered with procedure such as colonoscopy or endoscopy are not included.	*Evidence of administration of IV med at least once within the observation period must be available. Additives such as electrolytes and insulin, which are added to the resident's TPN or IV fluids, are included.*

MDS 2.0 LOCATION	*FIELD DESCRIPTION*	*CASE MIX DOCUMENTATION GUIDELINES*	*MINIMUM DOCUMENTATION STANDARDS*
P1a,g (page 3-183 to 3-184)	Oxygen Therapy ***(14-day look back)***	Oxygen therapy shall be defined as the administration of oxygen continuously or intermittently via mask, cannula, etc. Evidence of administration must be cited on the medical chart. (Does not include hyperbaric oxygen for wound therapy.)	*Evidence of administration of oxygen at least once within the observation period must be provided.*
P1a,h (page 3-183)	Radiation ***(14-day look back)***	Evidence includes radiation therapy or a radiation implant.	*If administered outside of facility, evidence of procedure occurring within the observation period must be provided.*
P1a,i (page 3-183)	Suctioning ***(14-day look back)***	Evidence of nasopharyngeal or tracheal aspiration must be cited in the medical chart. Oral suctioning is not permitted to be coded in this field.	*Nasopharyngeal or tracheal aspiration must be present at least once within the observation period.*
P1a,j (page 3-183)	Tracheostomy Care ***(14-day look back)***	Evidence of tracheostomy and cannula cleansing administered by staff must be cited in the medical chart.	*Evidence must support cannula cleansing by staff at least once within the observation period. Changing a disposable cannula is included.*
P1a,k (page 3-183)	Transfusions ***(14-day look back)***	Evidence of transfusions of blood or any blood products administered directly into the bloodstream by staff must be cited in the medical chart. Do not include transfusions that were administered during chemotherapy or dialysis.	*Evidence of transfusions of blood or any blood products administered directly into the bloodstream by staff at least once within the observation period must be present.*
P1a,l (page 3-183 to 3-184)	Ventilator or Respirator ***(14-day look back)***	Includes any type of electrically or pneumatically powered closed system mechanical ventilatory support devices. Any resident who was in the process of being weaned off the ventilator or respirator in the last 14 days should be coded. Does not include CPAP or BiPAP in this field.	*Does not include CPAP or BiPAP in this field.*

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P1b **a,b,c** **Col. A,B** (page 3-185 to 3-190)	Therapies ***(7-day look back)***	Days and minutes of each therapy must be cited in the medical chart on a daily basis to support the total days and minutes of direct therapy provided. Includes **only** medically necessary therapies furnished after admission to the nursing facility. Also includes **only** therapies ordered by a physician, based on a therapist's assessment and treatment plan that is documented in the clinical record. Group therapy is limited to four residents per session and only 25% of the total therapy minutes per discipline may be contributed to group therapy (section P1b,a-c).Therapy minutes provided simultaneously by two or more therapists must be split accurately between disciplines (section P1b,a-c). The time it takes to perform an initial evaluation and develop the treatment goals and the plan of care for the resident cannot be counted as minutes of therapy received by the resident. Re-evaluations, once therapy is underway, may be counted.	*Direct therapy days and minutes with associated signature(s) must be provided. Cannot count initial evaluation time. Must provide evidence of physician order.*

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MDS 2.0 LOCATION	*FIELD DESCRIPTION*	*CASE MIX DOCUMENTATION GUIDELINES*	*MINIMUM DOCUMENTATION STANDARDS*
P1b, d A (page 3-185 to 3-190)	Respiratory Therapy ***(7-day look back)***	Days and minutes of respiratory therapy must be cited in the medical chart on a daily basis to support the total days and minutes of direct therapy provided. Does not include hand held medication dispensers. Count only the time that the qualified professional spends with the resident. Includes only medically necessary therapies furnished after admission to the nursing facility. Also includes **only** therapies ordered by a physician, based on a therapist's assessment and treatment plan that is documented in the resident's clinical record. A trained nurse may perform the assessment and the treatments when permitted by the state practice act. ***** In lieu of the Licensed Respiratory Therapist, a "Trained Nurse" (only the Registered Nurse in Louisiana) may perform the Initial Respiratory Assessments and subsequent assessments after being trained by a Licensed Respiratory Therapist. (per Health Standards)** Qualified professionals for the delivery of respiratory services include "**trained nurses**." A trained nurse refers to a nurse who received specific training on the administration of respiratory treatments and procedures. This training may have been provided at the facility during a previous work experience or as part of an academic program. Nurses do not necessarily learn these procedures as part of their formal nurse training program.	*Direct therapy days and minutes with associated signature(s) must be provided. Qualified individuals for the delivery of respiratory services include "trained nurses". A trained nurse refers to a nurse who received training on the administration of respiratory treatments and procedures. Must provide evidence of nurse training.*

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MDS 2.0 LOCATION	*FIELD DESCRIPTION*	*CASE MIX DOCUMENTATION GUIDELINES*	*MINIMUM DOCUMENTATION STANDARDS*
P3a-j NURSING REHAB/RESTORE SCORE ONLY (page 3-191 to 3-195)	Nursing Rehab/Restorative ***(7-day look back)***	Days of restorative nursing must be cited in the medical chart on a daily basis. Minutes of service must be provided daily to support the program and total time that is then converted to days on the MDS. Documentation must meet the five criteria of a nursing restorative program. Dentures are **not** considered to be prostheses for coding this item. Nursing rehabilitation/restorative care includes nursing interventions that assist or promotes the resident's ability to attain his or her maximum functional potential. It does not include procedures under the direction and delivery of qualified, licensed therapists. Nursing Restorative criteria must be met as defined on page 3-192 of the RAI manual. The five criteria required to constitute a nursing restorative program are: 1). Care plan with measurable objectives and interventions 2). Periodic evaluation by a licensed nurse 3). Staff trained in the proper techniques 4). Supervision by nursing 5). No more than 4 residents per supervising staff personnel	*Documentation must meet the five criteria of a nursing restorative program. Direct restorative days and minutes with associated signature (s) and date(s) must be provided.* *Active ROM includes Active Assisted ROM.* *Must specify either Active or Passive ROM. "ROM" is not sufficient for the review.*
P7 (page 3-204 to 3-205)	Physician visits ***(14-day look back)***	Evidence includes the **number of days** (NOT NUMBER OF VISITS) in the last 14 days a physician examined the resident. Can occur in the facility or in the physician's office. A licensed psychologist may not be included for a visit.	*Must include documentation establishing an exam by the physician to be counted as a visit.*

MDS 2.0 LOCATION	*FIELD DESCRIPTION*	*CASE MIX DOCUMENTATION GUIDELINES*	*MINIMUM DOCUMENTATION STANDARDS*
P8 (page 3-205 to 3-206)	Physician orders ***(14-day look back)***	Evidence includes the **number of days** (NOT NUMBER OF ORDERS) in the last 14 days a physician changed the resident's orders. Includes written, telephone, fax, or consultation orders for **new or altered treatment**. Does not include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. A licensed psychologist may not be included for an order. Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.	*Documentation must include evidence of days with new or altered physician orders.*

Restorative Nursing Defined for Case Mix

Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy. A resident may also be started on a restorative program when a restorative need arises during the course of a custodial stay and they are not a candidate for a more formalized therapy program. Restorative nursing is a nursing function and does not require a physician's order or oversight by a licensed therapist. Assessment skills are crucial. To remain in a restorative nursing program, the resident must maintain or retain level of functioning. In addition, rehabilitation or restorative care **must meet all of the following criteria:**

- The **individual** problem must be clearly identified (ex. AROM, splint or brace assistance, transfer, walking, grooming, etc.)
- **Measurable** goals (objectives) and **measurable** interventions (actions) are clearly documented (care planned) for **each individual program.** (For something to be measurable it must have a particular unit of measurement attached to it, e.g. a time-scale, a weight or a distance and it must be measured against a particular goal or standard).

  Goals should be 'specific, reasonable, moderately challenging and attainable within a short space of time'. These short-term goals should be seen in the context of long-term achievement. Cannot include "canned" or "one-size-fits-all" "pre-printed" care plan for each program. These do not address the individual or their needs.
- A periodic evaluation by a licensed nurse is present in the resident's record for **each individual restorative program**
- Nurse assistants/aides are trained in the techniques that promote resident involvement in the activity
- The activities are supervised by a licensed nurse, although these interventions may be carried out by nurse assistants/aides, other staff or volunteers,
- Groups with more than four residents per supervising helper or caregiver are not included
- The technique, procedure or activity practiced total at least 15 minutes during a 24-hour period to report one day of restorative.

Documentation Requirements for Case Mix:

The Restorative Nurse must care plan each problem; establish measurable goals and measurable interventions specific to each individual resident.

The MDS requires each technique, procedure or activity practiced totals a minimum of 15 minutes during a 24-hour period. For the RUG-III classification at least six of the seven days during the observation period must be reported for **each** problem addressed. The case mix reviewers are required to review actual minutes provided each day and signed by the staff providing the service.

Interventions may be carried out by nurse assistants/aides, or other staff or volunteers. However, a periodic evaluation of each problem the resident is receiving restorative services for must be documented by a licensed nurse.

Month _____ *Year* _____

Restorative Care/Scheduled Toileting/Turning and Repositioning Care Plan and Flow Record

Directions: Use one page for each program. Complete and describe program, problem, goal, and interventions. Be specific. Record restorative minutes on a service basis in shift box for P3 restorative items. Be sure to initial service and sign form (full signature, title). Complete documentation checkpoint on back of form weekly/monthly to assure supporting documentation. Licensed nurse must evaluate resident's response to program on periodic basis on back of form. For case mix review the program must be evaluated during the observation period.

Program:

_____

Problem:

_____

_____

Goal:

_____

_____

Interventions:

_____

_____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
11-7 min.																															
Initial																															
7-3 min.																															
Initial																															
3-11 min.																															
Initial																															

Initials	Full Signature and Title	Initials	Full Signature and Title

Resident Name	Medical Record Number	Medical Record Number

Month _____ *Year* _____

Restorative Care/Scheduled Toileting/Turning and Repositioning Care Plan and Flow Record

Nursing Restorative Services:

H3a*	Any scheduled toileting plan
H3b*	Bladder retraining program
P3a*	Range of motion (passive)
P3b*	Range of motion (active)
P3c	Splint or brace assistance
P3d*	Bed mobility
P3f*	Walking
P3e	Transfer
P3g	Dressing or grooming
P3h	Eating or swallowing
P3i	Amputation/prosthesis care
P3j	Communication

Nursing Restorative Criteria:

*To be included in this section, a nursing rehabilitation or restorative practice must meet all of the following additional criteria:

*Measurable objectives and interventions must be documented in the care plan and in the clinical record.

*Evidence of periodic evaluation by licensed nurse must be present in the clinical record.

*Nurse assistants/aides must be trained in the techniques that promote resident involvement in the activity.

*These activities are carried out or supervised by members of the nursing staff.

*This category does not include groups with more than four residents per supervising helper or caregiver.

*Count as one service (H3a and b; P3a and b; P3d and f) even if both provided

Documentation checkpoint

Documentation checkpoint

Yes No Are NR days and minutes complete, dated, signed and accurate?

Yes No Are the 5 NR criteria met? (see page 7, Nursing Restorative)

_____

_____

Licensed Nurse evaluation of resident's response to program: Date: _____

_____

_____

_____

_____

Restorative Aide Notes:

_____

_____

_____

_____

Resident Name	Medical Record Number	Medical Record Number

RAI CLARFICATION: 02/2005

RAI Manual Section P1bd: Respiratory Therapy:

In lieu of the Licensed Respiratory Therapist, a "Trained Nurse" (**only the Registered Nurse in LA**) may perform the Initial Respiratory Assessments and subsequent assessments after being trained by a Licensed Respiratory Therapist. The nurse may have also been trained in a special academic program, as well. For instance, a Registered Nurse (RN) took a special course on Respiratory Therapy and may have received some type of certification as a Certified Respiratory Therapy Nurse. There must be documentation to verify that the Registered Nurse received such training on the administration of respiratory treatment. The "Trained Nurse" may train other Registered Nurses to perform the assessments and evaluations.

NOTE: The trained Licensed RN must conduct those assessments (initial and subsequent) periodically and based on the needs of the resident and the treatment plan needs to be altered.

In order for the **trained** Licensed Registered Nurse, Licensed Practical/Vocational Nurse or Respiratory Therapist to claim those therapy minutes, there **must be** documented evidence of:

- **An assessment**
- **Treatment plan**
- **Implementation of the treatment**
- **Monitoring of the resident's condition**
- **Evaluation of the treatment plan.**
- **Physician's Order**

Example 1: The **trained** RN, LPN or LVN prepares the nebulizer treatment, brings the set-up to the resident's room. The nurse gives the nebulizer to the resident and leaves the room. The nurse returns to the resident's room after the treatment is completed.

As per CMS instructions, this would not meet the definition of the intent for Respiratory Therapy Treatments.

Example 2: The **trained** RN, LPN or LVN prepares the nebulizer treatment, brings the set-up to the resident's room. The nurse administers the nebulizer treatment and remains in the resident's room, as she monitors the resident's condition and response to the treatment. The nurse documents the resident's condition and response to the treatment. The LPN/LVN must report untoward changes to the RN for further investigation. The **RN** will then conduct the assessment, make appropriate changes to the treatment plan and consult the physician, if applicable.

As per CMS instructions, this would meet the definition of the intent for Respiratory Therapy Treatments.

Month _____ *Year* _____

Respiratory Therapy Evaluations and Flow Record

Directions: Trained Registered Nurse (or Respiratory Therapist) must complete initial assessment and document plan of treatment. Each nurse completing respiratory treatments must be trained in the treatment being provided. Treatment must be ordered by a physician, be medically necessary and be documented in the clinical record. Count only the time the qualified professional spends with the resident.
NOTE: A trained Registered Nurse may perform the assessment and treatments.

Registered Nurse Initial Evaluation/Assessment: Might include such items as lung sounds, congestion, cough, sputum, dyspnea, oxygen, suctioning, trach care, call to physician, new orders, etc.

_____

_____

_____

_____

Treatment Order: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
11-7mins																															
Initial																															
7-3 mins																															
Initial																															
3-11mins																															
Initial																															

Initials	Full Signature and Title	Initials	Full Signature and Title

Resident Name	Medical Record Number	Medical Record Number

Month _____ *Year* _____

Respiratory Therapy Evaluations and Flow Record

Additional Nurse's notes:

Resident Name	Medical Record Number	Medical Record Number

CMI Reports

LOUISIANA CASE MIX SYSTEM

Final Case Mix Index Report

Print Date: 03/18/2004

Point in Time Date 01/01/2004

Provider Number: 5bbbb
Provider Name: XYZ NURSING CENTER

Resident Name	SSN	Resident ID	AA8a,b	Effective Date (R2b)	RUG Code	RUG Category	Notes	Payment Source	Index
			09	11/12/2003	SE2	Extensive Special Care 2 / ADL > 6	A	Other	1.7900
			09	12/12/2003	PA1	Reduced Physical Function / ADL 4-5	A	Medicaid	0.5900
			05	11/05/2003	SSA	Special Care / ADL 4-14		Medicaid	1.2800
			05	11/18/2003	PE1	Reduced Physical Function / ADL 16-18		Medicaid	0.9700
			05	11/10/2003	PE1	Reduced Physical Function / ADL 16-18		Medicaid	0.9700
			03	10/15/2003	CA2	Clinically Complex with Depression / ADL 4-11		Medicaid	1.0600
			01	12/30/2003	CA1	Clinically Complex / ADL 4-11		Medicaid	0.9500
			05	10/22/2003	IB1	Cognitive Impairment / ADL 6-10		Medicaid	0.8500
			03	11/17/2003	CA2	Clinically Complex with Depression / ADL 4-11		Other	1.0600
			05	12/17/2003	PB1	Reduced Physical Function / ADL 6-8		Medicaid	0.6300
			05	10/22/2003	SSA	Special Care / ADL 4-14		Medicaid	1.2800
			00, 2	12/23/2003	SSA	Special Care / ADL 4-14		Medicare	1.2800
			05	11/10/2003	PA1	Reduced Physical Function / ADL 4-5		Medicaid	0.5900
			05	12/24/2003	CB1	Clinically Complex / ADL 12-16		Medicaid	1.0700
			02	12/24/2003	CA1	Clinically Complex / ADL 4-11		Medicaid	0.9500
			05	10/22/2003	CA1	Clinically Complex / ADL 4-11		Medicaid	0.9500
			01	10/07/2003	PD1	Reduced Physical Function / ADL 11-15		Medicaid	0.8900
			05	10/22/2003	PA1	Reduced Physical Function / ADL 4-5		Medicaid	0.5900
			00, 2	12/24/2003	RAA	Rehabilitation All Levels / ADL 4-9		Medicare	1.0700
			05	12/03/2003	PA1	Reduced Physical Function / ADL 4-5		Other	0.5900
			03	12/10/2003	IB1	Cognitive Impairment / ADL 6-10		Other	0.8500
			05	12/24/2003	PA1	Reduced Physical Function / ADL 4-5		Medicaid	0.5900
			01	10/15/2003	IA1	Cognitive Impairment / ADL 4-5		Other	0.6700
			01	10/29/2003	IB1	Cognitive Impairment / ADL 6-10		Other	0.8500
			00, 2	12/10/2003	RAB	Rehabilitation All Levels / ADL 10-13		Medicare	1.2400
			03	11/17/2003	IB1	Cognitive Impairment / ADL 6-10		Medicaid	0.8500
			02	12/10/2003	CA1	Clinically Complex / ADL 4-11		Medicaid	0.9500
			00, 2	12/12/2003	RAB	Rehabilitation All Levels / ADL 10-13		Medicare	1.2400
			09	10/31/2003	CB1	Clinically Complex / ADL 12-16	A	Medicaid	1.0700
			05	11/24/2003	IB1	Cognitive Impairment / ADL 6-10		Other	0.8500
			05	12/01/2003	PE1	Reduced Physical Function / ADL 16-18		Medicaid	0.9700
			05	12/29/2003	IA1	Cognitive Impairment / ADL 4-5		Medicaid	0.6700
			03, 2	12/01/2003	RAA	Rehabilitation All Levels / ADL 4-9		Medicare	1.0700

Assessments transmitted and accepted on or before 03/08/2004

LOUISIANA CASE MIX SYSTEM

Final Case Mix Index Report

Point in Time Date 01/01/2004

Provider Number: 5bbbb
Provider Name: XYZ NURSING CENTER

Resident Name	SSN	Resident ID	AA8a,b	Effective Date (R2b)	RUG Code	RUG Category	Notes	Payment Source	Index
			01	11/14/2003	PA1	Reduced Physical Function / ADL 4-5		Medicaid	0.5900
			01	11/14/2003	PA1	Reduced Physical Function / ADL 4-5		Medicaid	0.5900
			03	12/04/2002	BC1	Delinquent Assessment	F	Medicaid	0.5900
			00, 2	12/08/2003	SSC	Special Care / ADL 17-18		Medicare	1.4400
			05	10/29/2003	CA1	Clinically Complex / ADL 4-11		Medicaid	0.9500
			09	11/21/2003	BC1	Delinquent Assessment	D	Other	0.5900
			05	10/29/2003	PA1	Reduced Physical Function / ADL 4-5		Medicaid	0.5900
			00, 7	12/30/2003	SSB	Special Care / ADL 15-16		Medicare	1.3300

LOUISIANA CASE MIX SYSTEM

Final Case Mix Index Report

Print Date: 03/18/2004

Point in Time Date 01/01/2004

Provider Number: 5bbbb
Provider Name: XYZ NURSING CENTER

Resident Name	SSN	Resident ID	AA8a,b	Effective Date (R2b)	RUG Code	RUG Category	Notes	Payment Source	Index
			03, 1	10/06/2003	SE2	Extensive Special Care 2 / ADL > 6		Medicare	1.7900

RUG Distribution Totals

Extensive Services	2
Rehabilitation	4
Special Care	5
Clinically Complex	9
Impaired Cognition	7
Behavior Problems	0
Reduced Physical Function	13
Delinquent	2
Total Residents	42

Total Residents and CMI Averages

Medicaid Residents:	26	0.8473
Medicare Residents:	8	1.3075
Other Residents:	8	0.9063
Total Residents:	42	0.9462

Notes

A. This reentry form is preceded with an assessment that is active and is assigned the RUG-III code applicable to the preceding assessment.

D. This reentry form is preceded by a Discharge Tracking form and no other assessment. A BC1 RUG-III code is assigned.

F. This assessment is greater than 121 days from the R2b (completion date) and is assigned the RUG-III code of BC1 denoting delinquency.

State of Louisiana
Department of Health and Hospitals
Note Field for Louisiana CMI Report

A. This reentry form is preceded with an assessment that is active and is assigned the RUG-III code applicable to the preceding assessment.

B. This reentry form is preceded with an assessment that is greater than 121 days from the R2b (completion date) and is assigned the RUG-III code of BC1 denoting delinquency.

C. This reentry form has no assessment or record preceding this reentry and is assigned a BC1 RUG-III code.

D. This reentry form is preceded by a Discharge Tracking form and no other assessment. A BC1 RUG-III code is assigned.

E. This reentry is followed with a new assessment started within the calendar quarter but contains an R2b date later than the calendar quarter date. No RUG-III code is assigned.

F. This assessment is greater than 121 days from the R2b (completion date) and is assigned the RUG-III code of BC1 denoting delinquency.

R. This assessment's original RUG-III code has been replaced with a RUG-III code based on the documentation provided during the MDS review.

State of Louisiana
Department of Health and Hospitals
RUG Distribution on CMI Report When Note Applied

Examples reference quarter 4/01/year

CMI Report NOTE	*Note Description*	*Assessment Scenario*	*Assessment and RUG-III Display on CMI Report*
A	This reentry form is preceded with an assessment that is active and is assigned the RUG-III code applicable to the preceding assessment.	Quarterly Assessment 1/30/year CA1 Discharge Tracking 3/10/year Reentry Tracking 3/12/year **End of Quarter 4/01/year**	Reentry Tracking Form 3/12/year **CA1**
B	This reentry form is preceded with an assessment that is greater than 121 days from the R2b (completion date) and is assigned the RUG-III code of BC1 denoting delinquency.	Admission Assessment 11/10/year PC2 Discharge Tracking 3/10/year Reentry Tracking 3/12/year **End of Quarter 4/01/year**	Reentry Tracking Form 3/12/year **BC1**
C	This reentry form has no assessment or record preceding this reentry and is assigned a BC1 RUG-III code.	No Assessment Reentry Tracking 3/18/year **End of Quarter 4/01/year** No Assessment	Reentry Tracking Form 3/18/year **BC1**
D	This reentry form is preceded by a Discharge Tracking form and no other assessment. A BC1 RUG-III code is assigned.	No Assessment Discharge Tracking Form 3/12/year Reentry Tracking 3/18/year **End of Quarter 4/01/year** No Assessment	Reentry Tracking Form 3/18/year **BC1**
E	This reentry is followed with a new assessment started within the calendar quarter but contains an R2b date later than the calendar quarter date. No RUG-III code is assigned.	Reentry Tracking 3/29/year Annual Assessment (R2b 4/11/year)	Reentry Tracking Form 3/29/year **No RUG-III Assignment**

RUG Distribution on CMI Report When Note Applied

Continued

F	This assessment is greater than 121 days from the R2b (completion date) and is assigned the RUG-III code of BC1 denoting delinquency.	Quarterly Assessment 10/3/year IB2 No subsequent assessments **End of Quarter 4/01/year**	Quarterly Assessment Form 10/3/year **BC1**
R	This assessment's original RUG-III code has been replaced with a RUG-III code based on the documentation provided during the MDS review.	Quarterly Assessment 3/25/year (IB2) Case Mix Review Quarterly Assessment 3/25/year (PB1) **End of Quarter 4/01/year**	Quarterly Assessment **PB1**

General CMI Report Assessment Issues

CMI Report Findings	*CMI Report Considerations*	*CMI Actions*
Resident assessment displayed on CMI report and shouldn't be.	1. Verify if resident was discharged 2. Verify that all resident identifying information is correct	1. Transmit Discharge Tracking form 2. Correct any inaccurate resident identifying information and retransmit assessment
Resident assessment not displayed on CMI report and should be.	1. Verify that most recent assessment was transmitted. 2. Verify that Reentry Tracking form was transmitted. 3. Admission assessment was never transmitted. 4. Assessment was rejected by the State. 5. Verify that all resident identifying information is correct.	1. Transmit most recent assessment 2. Transmit Reentry form 3. Transmit Admission assessment 4. Correct error and retransmit 5. Correct any inaccurate resident identifying information and retransmit assessment
Resident assessment displayed on CMI report with a BC1 RUG code.	1. Greater than 121 days have passed without another transmitted assessment 2. Resident has reentered and the preceding assessment is greater than 121 days old and no new assessment was completed within 14 days of the reentry date. 3. The reentry tracking form has no preceding assessment	1. Do nothing if no assessment If assessment completed, transmit 2. Do nothing If assessment completed, transmit 3. Do nothing
Same resident displayed on CMI report with two different assessments.	1. One or more of the resident identifiers has been transmitted with inaccurate data	1. Correct any inaccurate resident identifying information and retransmit assessment
Resident assessment displayed on CMI report but is not the correct assessment.	1. One or more of the resident identifiers has been transmitted with inaccurate data 2. A later assessment was not transmitted. 3. A later assessment was transmitted but rejected by the State	1. Correct any inaccurate resident identifying information and retransmit assessment 2. Transmit assessment 3. Correct any inaccuracy and retransmit assessment

State of Louisiana
Department of Health and Hospitals
Case Mix Index Report Process

Assessment Transmission Due Date and Report Due Date

MDS assessments completed with an R2b date on or before the point in time date provided on the CMI Report	*Assessments transmitted Prior to:*	*CMI Report Type*	*Rate for Quarter*
(CMI Report dated 10-01-year) July, August, September Assessments	November 1	November 15 Preliminary	January February March
	December 1	**December 15 Final**	
(CMI Report dated 01-01-year) October, November, December Assessments	February 1	February 15 Preliminary	April May June
	March 1	**March 15 Final**	
(CMI Report dated 04-01-year) January, February, March Assessments	May 1	May 15 Preliminary	July August September
	June 1	**June 15 Final**	
(CMI Report dated 07-01-year) April, May, June Assessments	August 1	August 15 Preliminary	October November December
	September 1	**September 15 Final**	

Louisiana Department of Health and Hospitals – CMI Listing Report and Transmission Schedule

January 2005

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

February 2005

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28					

March 2005

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

April 2005

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

May 2005

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

June 2005

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

July 2005

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

August 2005

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

September 2005

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

October 2005

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

November 2005

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

December 2005

1S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Tan Day of Month

Final date for MDS transmission for the Preliminary CMI Listing Report

Blue Day of Month

Date that the Preliminary CMI Listing Reports are mailed to Providers (usually the 15th day of the month)

Green Day of the Month

Final date for MDS transmission for the Final CMI Listing Report

Yellow Day of Month

Point in time date of the Final CMI Listing Report. Any assessment with an R2b date on or before this date will be listed

Rose Day of Month

Date that the Final CMI Listing Reports are mailed to Providers (usually the 15th of the month)

ADL Samples

RUG-III, Version 5.12 Classification Model
34-Grouper

The RUG-III Classification system has seven major resident classification groups: Extensive Services, Rehabilitation, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Functions. The seven groups are further divided by the intensity of the resident's activities of daily living (ADL) needs. In the Extensive Services category, an extensive services count is completed to determine if the assessment also meets the criteria in Special Care, Clinically Complex and Impaired Cognition. In the Clinically Complex category, assessments are differentiated by the absence or presence of depression. And, in the Impaired Cognition, Behavior Problems and Reduced Physical Functions categories, two or more nursing restorative services are recognized. This guide translates the computer programming into words and has been carefully reviewed to insure that it represents the standard RUG-III logic.

One very important calculation in the classification process is the scoring of Activities of Daily Living (ADL). An ADL Score is calculated for all assessment classifications and is one of the determining factors regarding placement in a RUG-III category. The ADL Score calculation includes G1a (bed mobility), G1b (transfer), G1i (toilet use), and an eating calculation. The ADL Scores range between 4 and 18. An ADL Score of 4 represents the most independent resident while a score of 18 represents the most dependent resident.

Other ADLs are also very important, but the national researchers have determined that the late loss ADLs (bed mobility, transfer, eating, and toilet use) are more predictive of resource use. The researchers determined that including the early loss ADLs did not significantly change the classification hierarchy or add to the variance explanation.

In the 34-group model there are 4 categories in the Rehabilitation group and different levels of rehabilitation service are not distinguished. The simplified Rehabilitation classification in the 34-group model is better suited to long-term care programs, which often classify on the basis of nursing care needs only. Medicaid long-term care programs in many States are examples. In the 34-group model, the Extensive Services groups have the highest level of nursing care needs, while the Rehabilitation groups have the next highest level of need. For this reason, the order of the Rehabilitation and Extensive Services groups are reversed in the 34-group model, with the Extensive Services groups first in comparison to the 44-group model.

HIERARCHICAL VERSUS INDEX MAXIMIZING CLASSIFICATION

There are two basic approaches to RUG-III classification: hierarchical classification and index maximizing classification. This guide is focused on the hierarchical approach but can be adapted to the index maximizing approach. See below for a description of the two methodologies.

Hierarchical Classification

Hierarchical classification is used in some payment systems, in staffing analysis, and in many research projects. In the hierarchical approach, you start at the top of the RUG-III hierarchy and stop at the first group for which the assessment qualifies. In other words, start with the Extensive Services groups at the top of the RUG-III model. Then work down through the groups in

hierarchical order: Extensive Services, Rehabilitation, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems and Reduced Physical Functions. Assign the first of the 34 individual RUG-III groups for which the assessment qualifies as the RUG-III classification.

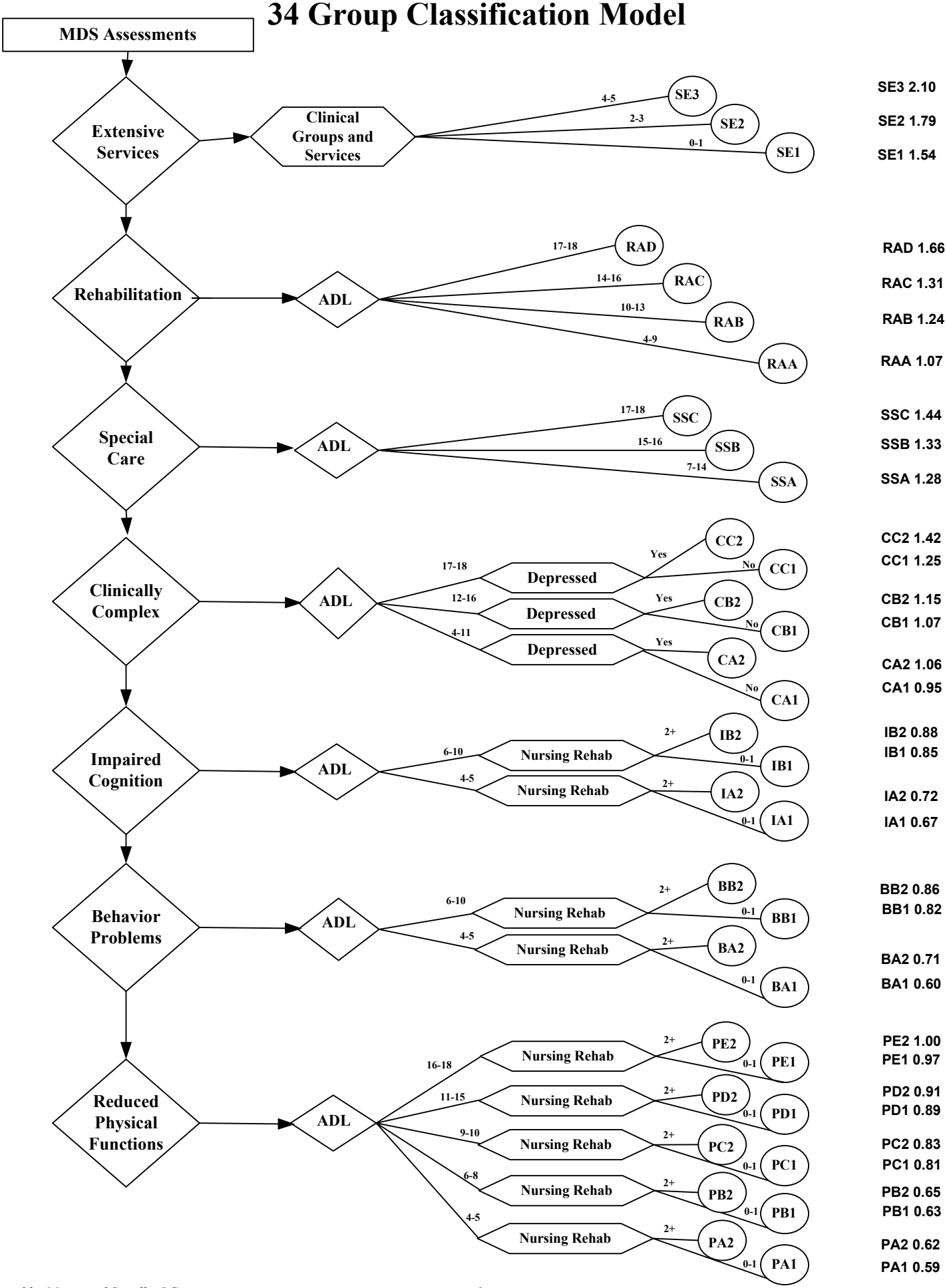
For example, if the assessment qualifies in one of the Extensive Services groups and also in the Rehabilitation group, always choose the Extensive Services classification, since it is higher in the RUG-III, 34-group hierarchy. Likewise, if the assessment qualifies for Special Care and Clinically Complex, always choose Special Care. In hierarchical classification, always pick the group nearer the top of the model.

Index Maximizing Classification

Index maximizing classification is used in many payment systems including Medicare and Medicaid. The first step in index maximizing is to determine all of the 34 individual RUG-III groups for which the assessment qualifies. Then, from the selected groups, pick the RUG-III classification with the highest Case Mix Index (CMI). In the resource utilization group systems, each category is assigned a weight. These weights represent the mean resource use of individuals within that group compared to the distribution of resident groups in the population. These weights or CMIs are used in the rate calculation to adjust for case mix.

For example, if the assessment qualifies in one of the Extensive Services groups and Rehabilitation group, choose the RUG-III classification with the higher CMI. Likewise, if the assessment qualifies for Special Care and Clinically Complex, again choose the RUG-III classification with the higher CMI. For index maximizing always pick the classification with the highest CMI.

Louisiana RUG-III, Version 5.12
34 Group Classification Model



Activities of Daily Living Calculation

The ADL Score calculation includes G1a (bed mobility), G1b (transfer), G1i (toilet use) and an eating calculation as described below:

Step 1: To calculate the score of G1a (Bed Mobility), G1b (Transfer), and G1i (Toilet Use), use the following chart. The eating ADL calculation will begin in Step #2. Place the transmitted values in the table below to determine the associated ADL Score for bed mobility, transfer and toilet use. Record the scores in the box in Step #3.

Column A =		Column B =	ADL Score
0 or 1	and	any number	= 1
2	and	any number	= 3
3, 4	and	0, 1 or 2	= 4
3, 4 or 8	and	3 or 8	= 5

Documentation Checkpoint

Yes ***No*** ***Is ADL documentation complete, dated, signed and accurate?***

Documentation Checkpoint

G1a _____
G1b _____
G1i _____
G1h _____

Step 2: **a)** To complete the Eating ADL Score calculation use the criteria below: *(only apply one eating ADL Score when the assessment is coded for IV and tube feed)*

K5a = checked	**ADL Score = 3 OR**
K5b = checked + K6a = 3 or 4	**ADL Score = 3 OR**
K5b = checked + K6a = 2 **AND** K6b = 2, 3, 4, 5	**ADL Score = 3**

Documentation Checkpoint

K5a = Parenteral/IV
K5b = Feeding Tube
K6a = Calories
K6b = Fluid Intake

K5a _____
K5b _____
K6a _____
K6b _____

b) If no parenteral/IV or feeding tube is coded, return to G1hA to calculate the **eating** score using the chart below. Record the scores in the box in Step #3.

Column A =	ADL Score =
0 or 1	= 1
2	= 2
3, 4 or 8	= 3

Step 3: The total ADL Score range possibilities are 4 through 18 and include the ADL sum for G1a, G1b, G1i and the eating score. Total ADL Score:

Bed Mobility (G1a) =	_____
Transfer (G1b) =	_____
Toilet Use (G1i) =	_____
Eating =	_____
Total ADL =	_____

ADL

Samples

2004

Self-Performance Key	Support Provided Key
0 =Independent--No help or oversight 1 =Supervision—Oversight, encouragement or cueing provided 2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided *Weight-bearing support *Full staff performance 4 =Total Dependence--Full staff performance of activity during entire shift 8 =Activity Did Not Occur on this shift *The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.*	0 =No setup or physical help from staff 1 =Setup help only 2 =One person physical assist 3 =Two+ persons physical assist 8 =Activity did not occur *The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.*

N=Nights D=Day E=Evenings

		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		A3a	
Date		9/15		9/16		9/17		9/18		9/19		9/20		9/21	
Bed Mobility – How resident moves to and from lying position, turns side to side, and positions body while in bed.															
			Int		Int		Int		Int		Int		Int		Int
Self Perform	N	4	FS	4	FS	4	FS	4	FS	4	BB	4	FS	4	BB
	D	4	ES	4	ES	4	KO	4	KO	4	ES	4	ES	4	ES
	E	4	KO	4	KO	4	KO	4	KO	4	BB	4	KO	4	BB
Support Provided	N	3		2		2		3		2		2		3	
	D	3		3		2		3		2		2		2	
	E	3		2		3		3		2		3		3	

Likely Transmitted Value _____ Review Value _____

Resident Name ANNIE APPLE Medical Record No. 101

ADL Score = _____ ADL Score = _____

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	*Fred Skeleton, CNA*	ES	*Ed Skeleton, CNA*	BB	*Betty Bones, RN*	KO	*Kelley Ostomy, LPN*

Rationale: _____

Example #1

Self-Performance Key

0 =Independent--No help or oversight
1 =Supervision—Oversight, encouragement or cueing provided
2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance
3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided
*Weight-bearing support
*Full staff performance
4 =Total Dependence--Full staff performance of activity during entire shift
8 =Activity Did Not Occur on this shift

The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

Support Provided Key

0 =No setup or physical help from staff
1 =Setup help only
2 =One person physical assist
3 =Two+ persons physical assist
8 =Activity did not occur

The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.

N=Nights D=Day E=Evenings

		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		A3a	
Date		9/15/04		9/16/04		9/17/04		9/18/04		9/19/04		9/20/04		9/21/04	
Transfers – How resident moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)															
			Int		Int		Int		Int		Int		Int		Int
Self Perform	N	8	FS	8	FS	8	FS	8	FS	8	BB	8	BB	8	BB
	D	2	TS	4	TS	2	ES	4	ES	2	ES	2	TS	2	TS
	E	2	TS	2	TS	2	ES	2	FS	2	ES	2	ES	2	ES
Support Provided	N	8		8		8		8		8		8		8	
	D	2		3		2		3		2		2		2	
	E	2		2		2		2		2		2		2	

Likely Transmitted Value _____ Review Value _____

_____ _____

Resident Name _____ **Medical Record No.** _____ **ADL Score =** **ADL Score =**

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	*Fred Skeleton, CNA*	BB	*Betty Bones, RN*	TS	*Ted Skeleton, CNA*	ES	*Ed Skeleton, CNA*

Rationale: _____
Example #2A

Self-Performance Key

0 =Independent--No help or oversight
1 =Supervision—Oversight, encouragement or cueing provided
2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance
3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided
*Weight-bearing support
*Full staff performance
4 =Total Dependence--Full staff performance of activity during entire shift
8 =Activity Did Not Occur on this shift

The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

Support Provided Key

0 =No setup or physical help from staff
1 =Setup help only
2 =One person physical assist
3 =Two+ persons physical assist
8 =Activity did not occur

The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.

N=Nights D=Day E=Evenings

		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		A3a	
Date		9/15/04		9/16/04		9/17/04		9/18/04		9/19/04		9/20/04		9/21/04	
Transfers – How resident moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)															
			Int		Int		Int		Int		Int		Int		Int
Self Perform	N	8	FS	8	FS	8	FS	8	FS	8	BB	8	BB	8	BB
	D	2	TS	4	TS	2	ES	4	ES	2	ES	2	TS	2	TS
	E	2	TS	2	TS	2	ES	2	FS	2	ES	2	ES	2	ES
Support Provided	N	8		8		8		8		8		8		8	
	D	2		3		2		3		2		2		2	
	E	2		2		2		2		2		2		2	

Likely Transmitted Value _____ Review Value _____

Resident Name _____ Medical Record No. 202

ADL Score = _____ ADL Score = _____

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	*Fred Skeleton, CNA*	BB	*Betty Bones, RN*	TS	*Ted Skeleton, CNA*	ES	*Ed Skeleton, CNA*

Rationale: _____

Example #2B

Self-Performance Key

0 =Independent--No help or oversight
1 =Supervision—Oversight, encouragement or cueing provided
2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance
3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided
*Weight-bearing support
*Full staff performance
4 =Total Dependence--Full staff performance of activity during entire shift
8 =Activity Did Not Occur on this shift

The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

Support Provided Key

0 =No setup or physical help from staff
1 =Setup help only
2 =One person physical assist
3 =Two+ persons physical assist
8 =Activity did not occur

The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.

N=Nights D=Day E=Evenings

		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		A3a	
Date		9/15/04		9/16/04		9/17/04		9/18/04		9/19/04		9/20/04		9/21/04	
Toilet Use – How resident uses the toilet room (commode, bedpan or urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.			Int		Int		Int		Int		Int		Int		Int
Self Perform	N	4	FS	4	FS	4	FS	4	FS	4	ES	4	ES	4	ES
	D	4	ES	3	ES	4	ES	4	RS	4	RS	4	RS	4	RS
	E	4	ES	4	TS	4	TS	4	RS	4	RS	4	TS	4	TS
Support Provided	N	3		3		3		3		3		3		3	
	D	3		3		3		3		3		3		3	
	E	3		3		3		3		3		3		3	

Likely Transmitted Value _____ Review Value _____

Resident Name BLUE BERRY Medical Record No. 303

ADL Score = _____ ADL Score = _____

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	*Fred Skeleton, CNA*	ES	*Ed Skeleton, CNA*	TS	*Ted Skeleton, CNA*	RS	*Red Skeleton, CNA*

Rationale: _____

Example #3A

Self-Performance Key	Support Provided Key
0 =Independent--No help or oversight 1 =Supervision—Oversight, encouragement or cueing provided 2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided *Weight-bearing support *Full staff performance 4 =Total Dependence--Full staff performance of activity during entire shift 8 =Activity Did Not Occur on this shift *The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.*	0 =No setup or physical help from staff 1 =Setup help only 2 =One person physical assist 3 =Two+ persons physical assist 8 =Activity did not occur *The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.*

N=Nights D=Day E=Evenings

		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		A3a	
Date		9/15/04		9/16/04		9/17/04		9/18/04		9/19/04		9/20/04		9/21/04	
Toilet Use – How resident uses the toilet room (commode, bedpan or urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.															
			Int		Int		Int		Int		Int		Int		Int
Self Perform	N	4	FS ES 9/17/04	4	FS	4	FS	4	FS	4	ES	4	ES	4	ES
	D	4	ES	3 4	ES	4	ES	4	RS	4	RS	4	RS	4	RS
	E	4	ES	4	TS	4	TS	4	RS	4	RS	4	TS	4	TS
Support Provided	N	3		3		3		3		3		3		3	
	D	3		3		3		3		3		3		3	
	E	3		3		3		3		3		3		3	

Likely Transmitted Value _____ Review Value _____

Resident Name BLUE BERRY Medical Record No. 303

ADL Score = _____ ADL Score = _____

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	*Fred Skeleton, CNA*	ES	*Ed Skeleton, CNA*	TS	*Ted Skeleton, CNA*	RS	*Red Skeleton, CNA*

Rationale: _____

Example #3B

Self-Performance Key	Support Provided Key
0 =Independent--No help or oversight 1 =Supervision—Oversight, encouragement or cueing provided 2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided *Weight-bearing support *Full staff performance 4 =Total Dependence--Full staff performance of activity during entire shift 8 =Activity Did Not Occur on this shift *The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.*	0 =No setup or physical help from staff 1 =Setup help only 2 =One person physical assist 3 =Two+ persons physical assist 8 =Activity did not occur *The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.*

N=Nights D=Day E=Evenings

		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		A3a	
Date		9/15/04		9/16/04		9/17/04		9/20/04		9/21/04		9/22/05		9/24/04	
Transfers – How resident moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)															
			Int		Int		Int		Int		Int		Int		Int
Self Perform	N	4	FS	4	FS	4	FS	2	BB	2	BB	3	BB	2	BB
	D	4	CO	4	CO	4	CO	1	CO	2	CO	3	BB	1	CO
	E	4	TS	4	TS	4	TS	2	TS	2	FS	3	FS	1	FS
Support Provided	N	3		3		3		2		2		3		2	
	D	3		3		3		1		2		3		1	
	E	3		3		3		2		2		3		1	

Likely Transmitted Value _____ Review Value _____

Resident Name CUE CUMBER Medical Record No. 404

ADL Score = _____ ADL Score = _____

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	*Fred Skeleton, CNA*	BB	*Betty Bones, RN*	CO	*Cole Ostomy, LPN*	TS	*Ted Skeleton, CNA*

Rationale: _____

Example #4A

Self-Performance Key	Support Provided Key
0 =Independent--No help or oversight 1 =Supervision—Oversight, encouragement or cueing provided 2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided *Weight-bearing support *Full staff performance 4 =Total Dependence--Full staff performance of activity during entire shift 8 =Activity Did Not Occur on this shift *The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.*	0 =No setup or physical help from staff 1 =Setup help only 2 =One person physical assist 3 =Two+ persons physical assist 8 =Activity did not occur *The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.*

N=Nights D=Day E=Evenings

		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		A3a	
Date		9/15/04		9/16/04		9/17/04		9/20/04		9/21/04		9/22/05		9/24/04	
Transfers – How resident moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)															
			Int		Int		Int		Int		Int		Int		Int
Self Perform	N	4	FS	4	FS	4	FS	2	BB	2	BB	3	BB	2	BB
	D	4	CO	4	CO	4	CO	1	CO	2	CO	3	BB	1	CO
	E	4	TS	4	TS	4	TS	2	TS	2	FS	3	FS	1	FS
Support Provided	N	3		3		3		2		2		3		2	
	D	3		3		3		1		2		3		1	
	E	3		3		3		2		2		3		1	

Likely Transmitted Value _____ Review Value _____

Resident Name CUE CUMBER Medical Record No. 404

ADL Score = _____ ADL Score = _____

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	*Fred Skeleton, CNA*	BB	*Betty Bones, RN*	CO	*Cole Ostomy, LPN*	TS	*Ted Skeleton, CNA*

Rationale: _____

Example #4A

Self-Performance Key	Support Provided Key
0 =Independent--No help or oversight 1 =Supervision—Oversight, encouragement or cueing provided 2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided *Weight-bearing support *Full staff performance 4 =Total Dependence--Full staff performance of activity during entire shift 8 =Activity Did Not Occur on this shift *The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.*	0 =No setup or physical help from staff 1 =Setup help only 2 =One person physical assist 3 =Two+ persons physical assist 8 =Activity did not occur *The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.*

N=Nights D=Day E=Evenings

		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		A3a	
Date		9/15/04		9/16/04		9/17/04		9/20/04		9/21/04		9/22/05		9/24/04	
Transfers – How resident moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)															
			Int		Int		Int		Int		Int		Int		Int
Self Perform	N	4	FS	4	FS	4	FS	2	BB	2	BB	3	BB	2	BB
	D	4	CO	4	CO	4	CO	1	CO	2	CO	3	BB	1	CO
	E	4	TS	4	TS	4	TS	2	TS	2	FS	3	FS	1	FS
Support Provided	N	3		3		3		2		2		3		2	
	D	3		3		3		1		2		3		1	
	E	3		3		3		2		2		3		1	

Likely Transmitted Value _____ Review Value _____

Resident Name CUE CUMBER Medical Record No. 404

ADL Score = _____ ADL Score = _____

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	*Fred Skeleton, CNA*	BB	*Betty Bones, RN*	CO	*Cole Ostomy, LPN*	TS	*Ted Skeleton, CNA*

Rationale: _____

Example #4B

Self-Performance Key

0 =Independent--No help or oversight
1 =Supervision—Oversight, encouragement or cueing provided
2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance
3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided
*Weight-bearing support
*Full staff performance
4 =Total Dependence--Full staff performance of activity during entire shift
8 =Activity Did Not Occur on this shift

The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

Support Provided Key

0 =No setup or physical help from staff
1 =Setup help only
2 =One person physical assist
3 =Two+ persons physical assist
8 =Activity did not occur

The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.

N=Nights D=Day E=Evenings

		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6 BB 9/22/04		A3a	
Date		9/15/04		9/16/04		9/17/04		9/20/04		9/21/04		9/22/04		9/24/04	
Transfers – How resident moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)															
			Int		Int		Int		Int		Int		Int		Int
Self Perform	N	4	FS	4	FS	4	FS	2	BB	2	BB	3	BB	2	BB
	D	4	CO	4	CO	4	CO	1	CO	2	CO	3	BB	1	CO
	E	4	TS	4	TS	4	TS	2	TS	2	FS	3	FS	1	FS
Support Provided	N	3		3		3		2		2		3		2	
	D	3		3		3		1		2		3		1	
	E	3		3		3		2		2		3		1	

Likely Transmitted Value _____ Review Value _____

Resident Name CUE CUMBER **Medical Record No.** 404

ADL Score = _____ ADL Score = _____

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	*Fred Skeleton, CNA*	BB	*Betty Bones, RN*	CO	*Cole Ostomy, LPN*	TS	*Ted Skeleton, CNA*

Rationale: _____

Example #4B

(Observation Period 9/15 – 9/21/04)

Self-Performance Key	Support Provided Key
0 =Independent--No help or oversight 1 =Supervision—Oversight, encouragement or cueing provided 2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided *Weight-bearing support *Full staff performance 4 =Total Dependence--Full staff performance of activity during entire shift 8 =Activity Did Not Occur on this shift *The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.*	0 =No setup or physical help from staff 1 =Setup help only 2 =One person physical assist 3 =Two+ persons physical assist 8 =Activity did not occur *The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.*

N=Nights D=Day E=Evenings

		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		A3a	
Date															
Eating-How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (tube feeding, total parenteral nutrition.															
			Int		Int		Int		Int		Int		Int		Int
Self Perform	N	1	FS	1	FS	2	FS	1	RS	2	RS	1	RS	1	RS
	D	0	ES	0	ES	0	ES	0	TS	0	RS	0	ES	0	ES
	E	1	ES	1	TS	1	TS	1	TS	1	TS	0	TS	1	TS

Likely Transmitted Value _____ Review Value _____

Resident Name CANDY APPLE Medical Record No. 505

ADL Score = ADL Score =

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	*Fred Skeleton, CNA*	ES	*Ed Skeleton, CNA*	TS	*Ted Skeleton, CNA*	RS	*Red Skeleton, CNA*

Rationale: _____

Example #5

EXAMPLE #5

Definition of (1) Supervision

Oversight, encouragement or cueing provided 3 or more times during last 7 days

OR

Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days

Self-Performance Key	Support Provided Key
0 =Independent--No help or oversight 1 =Supervision—Oversight, encouragement or cueing provided 2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided *Weight-bearing support *Full staff performance 4 =Total Dependence--Full staff performance of activity during entire shift 8 =Activity Did Not Occur on this shift *The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.*	0 =No setup or physical help from staff 1 =Setup help only 2 =One person physical assist 3 =Two+ persons physical assist 8 =Activity did not occur *The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.*

N=Nights D=Day E=Evenings

		Day 1		Day 2	Day 3	Day 4	Day 5	Day 6	A3a
Date		9/15/04							
Toilet Use – How resident uses the toilet room (commode, bedpan or urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.									
			Int	Int	Int	Int	Int	Int	Int
Self Perform	N								
	D	3	BB						
	E								
Support Provided	N								
	D	3							
	E								

HOSPITAL

Likely Transmitted Value _____ Review Value _____

Resident Name OLLIE ORANGE Medical Record No. 606

ADL Score = _____ ADL Score = _____

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
BB	*Betty Bones, RN*						

Rationale: _____

Example #6A

EXAMPLE #6A

9/15/04 10:00 am. Admitted Mrs. Orange from hospital following right hip ORIF. Alert, oriented. Staples intact. Surgical wound clean, no redness or drainage. Requires extensive assist with ADLs.

9/15/04 8:00 pm. Complaining of shortness of breath. Diaphoretic. Appears to be in acute distress. MD notified, and order received to send to ER for evaluation.

Self-Performance Key

0 =Independent--No help or oversight
1 =Supervision—Oversight, encouragement or cueing provided
2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance
3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided
*Weight-bearing support
*Full staff performance
4 =Total Dependence--Full staff performance of activity during entire shift
8 =Activity Did Not Occur on this shift

The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

Support Provided Key

0 =No setup or physical help from staff
1 =Setup help only
2 =One person physical assist
3 =Two+ persons physical assist
8 =Activity did not occur

The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.

N=Nights D=Day E=Evenings

		Day 1		Day 2	Day 3	Day 4	Day 5	Day 6	A3a
Date		9/15/04							
Toilet Use – How resident uses the toilet room (commode, bedpan or urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.									
			Int						
Self Perform	N			HOSPITAL					
	D	3	BB						
	E								
Support Provided	N								
	D	3							
	E								

Likely Transmitted Value _____ Review Value _____

Resident Name OLLIE ORANGE Medical Record No. 606

ADL Score = ADL Score =

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
BB	*Betty Bones, RN*						

Rationale: _____

Example #6A

EXAMPLE #6A

Definition of (0) Independent

No help or oversight

OR

Help/Oversight provided only 1 or 2 times during last 7 days. If the activity occurred less than three times in the look back period, code "0" Independent, regardless of level of assistance required.

Self-Performance Key

0 =Independent--No help or oversight
1 =Supervision—Oversight, encouragement or cueing provided
2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance
3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided
*Weight-bearing support
*Full staff performance
4 =Total Dependence--Full staff performance of activity during entire shift
8 =Activity Did Not Occur on this shift

The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

Support Provided Key

0 =No setup or physical help from staff
1 =Setup help only
2 =One person physical assist
3 =Two+ persons physical assist
8 =Activity did not occur

The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.

N=Nights D=Day E=Evenings

		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	A3a
Date		9/15/04						
Bed Mobility – How resident moves to and from lying position, turns side to side, and positions body while in bed.								
		Int	Int	Int	Int	Int	Int	Int
Self Perform	N							
	D	3*	BB					
	E							
Support Provided	N							
	D	3						
	E							

HOSPITAL

Likely Transmitted Value _____ Review Value _____

Resident Name OLLIE ORANGE Medical Record No. 606

ADL Score = ADL Score =

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
BB	*Betty Bones, RN*						

Rationale: _____

Example #6B1 **See nurse's note 9/15/04*

EXAMPLE #6B (1)

9/15/04 10:00 am. Admitted Mrs. Orange from hospital following right hip ORIF. Alert, oriented. Staples intact. Surgical wound clean, no redness or drainage. Requires extensive assist with ADLs. Able to feed self breakfast.

9/15/04 11:30 am. Required extensive assist of one for transfer from bed to wheelchair, extensive assist of one for toilet use one time this morning. Able to feed self AM snack. Staff propels wheelchair.

9/15/04 2:00 pm. Required extensive assist of two for toileting; extensive assist of two for transfers and bed mobility. Unable to stand and transfer alone. Unable to turn and reposition self in bed. Needed help managing clothing and transferring on and off toilet.

9/15/04 7:00 pm. Extensive assist of two for toileting; tired, complaining of pain to right hip. Fed self at supper with encouragement. Appetite fair. Extensive assist of two for transfer from chair to bed.

9/15/04 8:00 pm. Complaining of shortness of breath. Diaphoretic. Appears to be in acute distress. MD notified, and order received to send to ER for evaluation.

Self-Performance Key

0 =Independent--No help or oversight
1 =Supervision—Oversight, encouragement or cueing provided
2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance
3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided
*Weight-bearing support
*Full staff performance
4 =Total Dependence--Full staff performance of activity during entire shift
8 =Activity Did Not Occur on this shift

The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

Support Provided Key

0 =No setup or physical help from staff
1 =Setup help only
2 =One person physical assist
3 =Two+ persons physical assist
8 =Activity did not occur

The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.

N=Nights D=Day E=Evenings

		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	A3a
Date		9/15/04						
Bed Mobility – How resident moves to and from lying position, turns side to side, and positions body while in bed.								
		Int	Int	Int	Int	Int	Int	Int
Self Perform	N							
	D	3 *	BB					
	E							
Support Provided	N							
	D	3						
	E							

HOSPITAL

Likely Transmitted Value _____ Review Value _____

Resident Name OLLIE ORANGE Medical Record No. 606

ADL Score = ADL Score =

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
BB	*Betty Bones, RN*						

Rationale:

Example #6B1 **See nurse's note 9/15/04*

Self-Performance Key

0 =Independent--No help or oversight
1 =Supervision—Oversight, encouragement or cueing provided
2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance
3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided
*Weight-bearing support
*Full staff performance
4 =Total Dependence--Full staff performance of activity during entire shift
8 =Activity Did Not Occur on this shift

The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

Support Provided Key

0 =No setup or physical help from staff
1 =Setup help only
2 =One person physical assist
3 =Two+ persons physical assist
8 =Activity did not occur

The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.

N=Nights D=Day E=Evenings

		Day 1	Int	Day 2	Int	Day 3	Int	Day 4	Int	Day 5	Int	Day 6	Int	A3a	Int
Date		9/15/04													
Transfers – How resident moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)															
Self Perform	N			HOSPITAL											
	D	3*	BB												
	E														
Support Provided	N														
	D	3													
	E														

Likely Transmitted Value _____ Review Value _____

Resident Name OLLIE ORANGE Medical Record No. 606

ADL Score = ADL Score =

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
BB	*Betty Bones, RN*						

Rationale: *See nurse's note 9/15/04

Example #6B2

EXAMPLE #6B (2)

9/15/04 10:00 am. Admitted Mrs. Orange from hospital following right hip ORIF. Alert, oriented. Staples intact. Surgical wound clean, no redness or drainage. Requires extensive assist with ADLs. Able to feed self breakfast.

9/15/04 11:30 am. Required extensive assist of one for transfer from bed to wheelchair, extensive assist of one for toilet use one time this morning. Able to feed self AM snack. Staff propels wheelchair.

9/15/04 2:00 pm. Required extensive assist of two for toileting; extensive assist of two for transfers and bed mobility. Unable to stand and transfer alone. Unable to turn and reposition self in bed. Needed help managing clothing and transferring on and off toilet.

9/15/04 7:00 pm. Extensive assist of two for toileting; tired, complaining of pain to right hip. Fed self at supper with encouragement. Appetite fair. Extensive assist of two for transfer from chair to bed.

9/15/04 8:00 pm. Complaining of shortness of breath. Diaphoretic. Appears to be in acute distress. MD notified, and order received to send to ER for evaluation.

Self-Performance Key	Support Provided Key
0 =Independent--No help or oversight 1 =Supervision—Oversight, encouragement or cueing provided 2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided *Weight-bearing support *Full staff performance 4 =Total Dependence--Full staff performance of activity during entire shift 8 =Activity Did Not Occur on this shift *The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.*	0 =No setup or physical help from staff 1 =Setup help only 2 =One person physical assist 3 =Two+ persons physical assist 8 =Activity did not occur *The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.*

N=Nights D=Day E=Evenings

		Day 1		Day 2	Day 3	Day 4	Day 5	Day 6	A3a
Date		9/15/04							
Transfers – How resident moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)									
			Int						
Self Perform	N			HOSPITAL					
	D	3*	BB						
	E								
Support Provided	N								
	D	3							
	E								

Likely Transmitted Value

Review Value

Resident Name OLLIE ORANGE Medical Record No. 606

ADL Score =

ADL Score =

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
BB	*Betty Bones, RN*						

Rationale:

Example #6B2 **See nurse's note 9/15/04*

Self-Performance Key

0 =Independent--No help or oversight
1 =Supervision—Oversight, encouragement or cueing provided
2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance
3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided
*Weight-bearing support
*Full staff performance
4 =Total Dependence--Full staff performance of activity during entire shift
8 =Activity Did Not Occur on this shift

The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

Support Provided Key

0 =No setup or physical help from staff
1 =Setup help only
2 =One person physical assist
3 =Two+ persons physical assist
8 =Activity did not occur

The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.

N=Nights D=Day E=Evenings

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	A3a
Date	9/15/04						

Eating-How resident eats and drinks (regardless of skill).
Includes intake of nourishment by other means (tube feeding, total parenteral nutrition.

		Int		Int		Int		Int		Int		Int		Int
Self Perform	N	X	HOSPITAL											
	D	1 *												
	E	X												

Int: 1 * BB

Likely Transmitted Value _____ ADL Score = _____

Review Value _____ ADL Score = _____

Resident Name OLLIE ORANGE Medical Record No. 606

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
BB	*Betty Bones, RN*						

Rationale: _____

Example #6B3

**See nurse's note 9/15/04*

EXAMPLE #6B (3)

9/15/04 10:00 am. Admitted Mrs. Orange from hospital following right hip ORIF. Alert, oriented. Staples intact. Surgical wound clean, no redness or drainage. Requires extensive assist with ADLs. Able to feed self breakfast.

9/15/04 11:30 am. Required extensive assist of one for transfer from bed to wheelchair, extensive assist of one for toilet use one time this morning. Able to feed self AM snack. Staff propels wheelchair.

9/15/04 2:00 pm. Required extensive assist of two for toileting; extensive assist of two for transfers and bed mobility. Unable to stand and transfer alone. Unable to turn and reposition self in bed. Needed help managing clothing and transferring on and off toilet.

9/15/04 7:00 pm. Extensive assist of two for toileting; tired, complaining of pain to right hip. Fed self at supper with encouragement. Appetite fair. Extensive assist of two for transfer from chair to bed.

9/15/04 8:00 pm. Complaining of shortness of breath. Diaphoretic. Appears to be in acute distress. MD notified, and order received to send to ER for evaluation.

Self-Performance Key	Support Provided Key
0 =Independent--No help or oversight 1 =Supervision—Oversight, encouragement or cueing provided 2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided *Weight-bearing support *Full staff performance 4 =Total Dependence--Full staff performance of activity during entire shift 8 =Activity Did Not Occur on this shift *The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.*	0 =No setup or physical help from staff 1 =Setup help only 2 =One person physical assist 3 =Two+ persons physical assist 8 =Activity did not occur *The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.*

N=Nights D=Day E=Evenings

		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	A3a
Date		9/15/04						
Eating-How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (tube feeding, total parenteral nutrition.								
		Int	Int	Int	Int	Int	Int	Int
Self Perform	N	X	BB	HOSPITAL				
	D	1 *	BB					
	E	X	X					

Likely Transmitted Value _____ Review Value _____

ADL Score = _____ ADL Score = _____

Resident Name OLLIE ORANGE **Medical Record No.** 606

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
BB	*Betty Bones, RN*						

Rationale: _____

Example #6B3 _____

**See nurse's note 9/15/04*

Self-Performance Key

0 =Independent--No help or oversight
1 =Supervision—Oversight, encouragement or cueing provided
2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance
3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided
*Weight-bearing support
*Full staff performance
4 =Total Dependence--Full staff performance of activity during entire shift
8 =Activity Did Not Occur on this shift

The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

Support Provided Key

0 =No setup or physical help from staff
1 =Setup help only
2 =One person physical assist
3 =Two+ persons physical assist
8 =Activity did not occur

The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.

N=Nights D=Day E=Evenings

		Day 1		Day 2	Day 3	Day 4	Day 5	Day 6	A3a
Date		9/15/04							
Toilet Use – How resident uses the toilet room (commode, bedpan or urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.									
		Int		Int	Int	Int	Int	Int	Int
Self Perform	N								
	D	3*	BB						
	E								
Support Provided	N								
	D	3							
	E								

HOSPITAL

Likely Transmitted Value _____ Review Value _____

Resident Name OLLIE ORANGE Medical Record No. 606

ADL Score = ADL Score =

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
BB	*Betty Bones, RN*						

Rationale: _____

Example #6B4

**See nurse's note 9/15/04*

EXAMPLE #6B (4)

9/15/04 10:00 am. Admitted Mrs. Orange from hospital following right hip ORIF. Alert, oriented. Staples intact. Surgical wound clean, no redness or drainage. Requires extensive assist with ADLs. Able to feed self breakfast.

9/15/04 11:30 am. Required extensive assist of one for transfer from bed to wheelchair, extensive assist of one for toilet use one time this morning. Able to feed self AM snack. Staff propels wheelchair.

9/15/04 2:00 pm. Required extensive assist of two for toileting; extensive assist of two for transfers and bed mobility. Unable to stand and transfer alone. Unable to turn and reposition self in bed. Needed help managing clothing and transferring on and off toilet.

9/15/04 7:00 pm. Extensive assist of two for toileting; tired, complaining of pain to right hip. Fed self at supper with encouragement. Appetite fair. Extensive assist of two for transfer from chair to bed.

9/15/04 8:00 pm. Complaining of shortness of breath. Diaphoretic. Appears to be in acute distress. MD notified, and order received to send to ER for evaluation.

Self-Performance Key

0 =Independent--No help or oversight
1 =Supervision—Oversight, encouragement or cueing provided
2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance
3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided
*Weight-bearing support
*Full staff performance
4 =Total Dependence--Full staff performance of activity during entire shift
8 =Activity Did Not Occur on this shift

The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

Support Provided Key

0 =No setup or physical help from staff
1 =Setup help only
2 =One person physical assist
3 =Two+ persons physical assist
8 =Activity did not occur

The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.

N=Nights D=Day E=Evenings

		Day 1		Day 2	Day 3	Day 4	Day 5	Day 6	A3a
Date		9/15/04							
Toilet Use – How resident uses the toilet room (commode, bedpan or urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.									
			Int	Int	Int	Int	Int	Int	Int
Self Perform	N	X	X	HOSPITAL					
	D	3*	BB						
	E	X	X						
Support Provided	N	X							
	D	3							
	E	X							

Likely Transmitted Value _____ Review Value _____

Resident Name OLLIE ORANGE Medical Record No. 606

ADL Score = _____ ADL Score = _____

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
BB	*Betty Bones, RN*						

Rationale: _____

Example #6B4

**See nurse's note 9/15/04*

EXAMPLE #7

9/15/04 10:00 am. Weekly summary: Alert and oriented with periods of confusion. Skin intact. No mood or behavior problems. No restraints used. Appetite good. No weight loss. Needs limited assist with ADLs. No new problems.

EXAMPLE #7, continued

Transmitted values for ADLs:

G1			A	B
a.	**Bed Mobility**	How resident moves to and from lying position, turns side to side, and positions body while in bed	2	2
b.	**Transfer**	How resident moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	2	2
i.	**Toilet Use**	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	2	2
h.	**Eating**	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	2	2

ADL Score:

(G1a) Bed Mobility	2 – 2	= 3
(G1b) Transfer	2 – 2	= 3
(G1i) Toilet Use	2 – 2	= 3
(G1h) Eating	2	= 2
Total ADL Score		**= 11**

Reviewed values for ADLs:				
a.	Bed Mobility		0	0
b.	Transfers		0	0
i.	Toilet Use		0	0
h.	Eating		0	0

Reviewed ADL Score:

(G1a) Bed Mobility	0 – 0	= 1
(G1b) Transfer	0 – 0	= 1
(G1i) Toilet Use	0 – 0	= 1
(G1h) Eating	0	= 1
Total ADL Score		**= 4**

EXAMPLE #7

9/15/04 10:00 am. Weekly summary: Alert and oriented with periods of confusion. Skin intact. No mood or behavior problems. No restraints used. Appetite good. No weight loss. Needs limited assist with ADLs. No new problems.

NOTE: While this note explains why the MDS is coded limited assist for ADLs, it is not sufficient to support limited assist for the case mix review.

Self-Performance Key

0 =Independent--No help or oversight
1 =Supervision—Oversight, encouragement or cueing provided
2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance
3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided
*Weight-bearing support
*Full staff performance
4 =Total Dependence--Full staff performance of activity during entire shift
8 =Activity Did Not Occur on this shift

The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

Support Provided Key

0 =No setup or physical help from staff
1 =Setup help only
2 =One person physical assist
3 =Two+ persons physical assist
8 =Activity did not occur

The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.

N=Nights D=Day E=Evenings

		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		A3a	
Date		9/15/04		9/16/04		9/17/04		9/18/04		9/19/04		9/20/04		9/21/04	
Toilet Use – How resident uses the toilet room (commode, bedpan or urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.															
			Int		Int		Int		Int		Int		Int		Int
Self Perform	N	1	CS	1	AF	1	PN	1	CS	1	KO	1	CS	1	AF
	D	1	CS	1	KO	*3	KO	1	PN	1	PN	1	PN	1	KO
	E	1	KO	1	PN	1	AF	1	CS	1	AF	1	KO	1	AF
Support Provided	N	0		0		0		0		0		0		0	
	D	0		0		*2		0		0		0		0	
	E	0		0		0		0		0		0		0	

Likely Transmitted Value _____ Review Value _____

ADL Score = _____ ADL Score = _____

Resident Name BETTY BANANA **Medical Record No.** 802

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
CS	*Cinderella Smith, LPN*	KO	*Kelley Ostomy, LPN*	AF	*Andy Flu, LPN*	PN	*Patty Nurse, LPN*

Example # 8 *Rationale:* _____

EXAMPLE #8

Day 3 (7 – 3 Shift)

Received PRN Lasix due to increased edema of feet and ankles. Resident unable to get to the bathroom in time and had four incontinent episodes on this shift. Required extensive assistance for cleansing and changing incontinent pads and clothing after each incontinent episode.

Self-Performance Key	Support Provided Key
0 =Independent--No help or oversight 1 =Supervision—Oversight, encouragement or cueing provided 2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided *Weight-bearing support *Full staff performance 4 =Total Dependence--Full staff performance of activity during entire shift 8 =Activity Did Not Occur on this shift *The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.*	0 =No setup or physical help from staff 1 =Setup help only 2 =One person physical assist 3 =Two+ persons physical assist 8 =Activity did not occur *The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.*

N=Nights D=Day E=Evenings

		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		A3a	
Date		9/15/04		9/16/04		9/17/04		9/18/04		9/19/04		9/20/04		9/21/04	
Toilet Use – How resident uses the toilet room (commode, bedpan or urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.															
			Int		Int		Int		Int		Int		Int		Int
Self Perform	N	1	CS	1	AF	1	PN	1	CS	1	KO	1	CS	1	AF
	D	1	CS	1	KO	*3	KO	1	PN	1	PN	1	PN	1	KO
	E	1	KO	1	PN	1	AF	1	CS	1	AF	1	KO	1	AF
Support Provided	N	0		0		0		0		0		0		0	
	D	0		0		*2		0		0		0		0	
	E	0		0		0		0		0		0		0	

Likely Transmitted Value _____ Review Value _____

ADL Score = _____ ADL Score = _____

Resident Name BETTY BANANA **Medical Record No.** 802

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
CS	*Cinderella Smith, LPN*	KO	*Kelley Ostomy, LPN*	AF	*Andy Flu, LPN*	PN	*Patty Nurse, LPN*

Example # 8 *Rationale:* _____

**See nurse's note 9/17/04*

Self-Performance Key

0 =Independent--No help or oversight
1 =Supervision—Oversight, encouragement or cueing provided
2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance
3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided
*Weight-bearing support
*Full staff performance
4 =Total Dependence--Full staff performance of activity during entire shift
8 =Activity Did Not Occur on this shift

The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

Support Provided Key

0 =No setup or physical help from staff
1 =Setup help only
2 =One person physical assist
3 =Two+ persons physical assist
8 =Activity did not occur

The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.

N=Nights D=Day E=Evenings

		Day 1	Int	Day 2	Int	Day 3	Int	Day 4	Int	Day 5	Int	Day 6	Int	A3a	Int
Date		9/15/04		9/16/04		9/17/04		9/18/04		9/19/04		9/20/04		9/21/04	
Toilet Use – How resident uses the toilet room (commode, bedpan or urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.															
Self Perform *	N	F		F		F		F		F		F		F	
	D	O		O		O		O		O		O		O	
	E	L		L		L		L		L		L		L	
Support Provided	N	E		E		E		E		E		E		E	
	D	Y		Y		Y		Y		Y		Y		Y	
	E														

Likely Transmitted Value _____ Review Value _____

ADL Score = _____ ADL Score = _____

Resident Name PATTY PEAR Medical Record No. 908

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature

Rationale: _____

Example #9 * See nurse's note 9/21/04

EXAMPLE #9

9/21/04 10:00 am. Weekly summary: Alert and oriented with periods of confusion. Skin intact. No mood or behavior problems. No restraints used. Appetite good, feeds self. No weight loss. Needs assisted with ADLs. Has a foley catheter and requires total assist daily with toileting and foley care. No new problems.

Self-Performance Key

0 =Independent--No help or oversight
1 =Supervision—Oversight, encouragement or cueing provided
2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance
3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided
*Weight-bearing support
*Full staff performance
4 =Total Dependence--Full staff performance of activity during entire shift
8 =Activity Did Not Occur on this shift

The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

Support Provided Key

0 =No setup or physical help from staff
1 =Setup help only
2 =One person physical assist
3 =Two+ persons physical assist
8 =Activity did not occur

The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.

N=Nights D=Day E=Evenings

		Day 1	Int	Day 2	Int	Day 3	Int	Day 4	Int	Day 5	Int	Day 6	Int	A3a	Int
Date		9/15/04		9/16/04		9/17/04		9/18/04		9/19/04		9/20/04		9/21/04	
Toilet Use – How resident uses the toilet room (commode, bedpan or urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.															
Self Perform*	N	F		F		F		F		F		F		F	
	D	O		O		O		O		O		O		O	
	E	L		L		L		L		L		L		L	
Support Provided	N	E		E		E		E		E		E		E	
	D	Y		Y		Y		Y		Y		Y		Y	
	E														

Likely Transmitted Value _____ Review Value _____

Resident Name PATTY PEAR Medical Record No. 908

ADL Score = _____ ADL Score = _____

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature

Rationale: _____

Example #9

*See nurse's note 9/21/04

EXAMPLE #9

9/21/04 10:00 am. Weekly summary: Alert and oriented with periods of confusion. Skin intact. No mood or behavior problems. No restraints used. Appetite good, feeds self. No weight loss. Needs assisted with ADLs. Has a foley catheter and requires total assist daily with toileting and foley care. No new problems.

NOTE: While this note explains why the MDS is coded total assist for toilet use, it is not sufficient to support total assist for the case mix review.

Minimum Documentation Standards for Case Mix Review: Documentation requires 24 hours/7 days within the observation period while in the facility. Must have signatures and dates to authenticate the services provided.

Self-Performance Key

0 =Independent--No help or oversight
1 =Supervision—Oversight, encouragement or cueing provided
2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance
3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided
*Weight-bearing support
*Full staff performance
4 =Total Dependence--Full staff performance of activity during entire shift
8 =Activity Did Not Occur on this shift

The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

Support Provided Key

0 =No setup or physical help from staff
1 =Setup help only
2 =One person physical assist
3 =Two+ persons physical assist
8 =Activity did not occur

The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.

N=Nights D=Day E=Evenings

		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		A3a	
Date		9/15/04		9/16/04		9/17/04		9/18/04		9/19/04		9/20/04		9/21/04	
Bed Mobility – How resident moves to and from lying position, turns side to side, and positions body while in bed.															
			Int		Int		Int		Int		Int		Int		Int
Self Perform	N	2	FS	2	FS	2	FS	2	FS	2	RS	2	RS	2	RS
	D	2	ES	2	ES	2	ES	2	ES	2	RS	2	RS	2	ES
	E	2	TS	2	TS	2	TS	2	TS	2	FS	2	ES	2	TS
Support Provided	N	2		2		2		2		2		2		2	
	D	2		2		2		2		2		2		2	
	E	2		2		2		2		2		2		2	

Likely Transmitted Value _____ Review Value _____

Resident Name WRONG WAY Medical Record No. 1001

ADL Score = ADL Score =

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	*Fred Skeleton, CNA*	ES	*Ed Skeleton, CNA*	TS	*Ted Skeleton, CNA*	RS	*Red Skeleton, CNA*

Rationale: _____

Example #10

EXAMPLE #10

9/22/04 2:00 pm. Quarterly care plan note: ADL grid is incorrect. Following staff interviews and observation, it has been determined that Mr. Way requires extensive assist of one for bed mobility, transfers, toilet use and eating. He is alert but confused and disoriented.

Self-Performance Key

0 =Independent--No help or oversight
1 =Supervision—Oversight, encouragement or cueing provided
2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance
3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided
*Weight-bearing support
*Full staff performance
4 =Total Dependence--Full staff performance of activity during entire shift
8 =Activity Did Not Occur on this shift

The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

Support Provided Key

0 =No setup or physical help from staff
1 =Setup help only
2 =One person physical assist
3 =Two+ persons physical assist
8 =Activity did not occur

The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.

N=Nights D=Day E=Evenings

Error – See nurse's Note 9/22/04

		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		A3a	
Date		9/15/04		9/16/04		9/17/04		9/18/04		9/19/04		9/20/04		9/21/04	
Bed Mobility – How resident moves to and from lying position, turns side to side, and positions body while in bed.															
			Int		Int		Int		Int		Int		Int		Int
Self Perform	N	2	FS	2	FS	2	FS	2	FS	2	RS	2	RS	2	RS
	D	2	ES	2	ES	2	ES	2	ES	2	RS	2	RS	2	ES
	E	2	TS	2	TS	2	TS	2	TS	2	FS	2	ES	2	TS
Support Provided	N	2		2		2		2		2		2		2	
	D	2		2		2		2		2		2		2	
	E	2		2		2		2		2		2		2	

Likely Transmitted Value _____ Review Value _____

Resident Name WRONG WAY Medical Record No. 1001

ADL Score = _____ ADL Score = _____

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	*Fred Skeleton, CNA*	ES	*Ed Skeleton, CNA*	TS	*Ted Skeleton, CNA*	RS	*Red Skeleton, CNA*

Rationale: _____

Example #10

Self-Performance Key	Support Provided Key
0 =Independent--No help or oversight 1 =Supervision—Oversight, encouragement or cueing provided 2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided *Weight-bearing support *Full staff performance 4 =Total Dependence--Full staff performance of activity during entire shift 8 =Activity Did Not Occur on this shift *The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.*	0 =No setup or physical help from staff 1 =Setup help only 2 =One person physical assist 3 =Two+ persons physical assist 8 =Activity did not occur *The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.*

N=Nights D=Day E=Evenings

		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		A3a	
Date		9/15/04		9/16/04		9/17/04		9/18/04		9/19/04		9/20/04		9/21/04	
Bed Mobility – How resident moves to and from lying position, turns side to side, and positions body while in bed.															
			Int		Int		Int		Int		Int		Int		Int
Self Perform	N	4	BB	4	BB	4	BB	4	NB	4	NB	4	NB	4	BB
	D	4	LB	4	LB	4	TS	4	TS	4	TS	4	LB	4	LB
Support Provided	N	2		2		2		2		2		2		2	
	D	2		2		2		2		2		2		2	

Likely Transmitted Value _____ Review Value _____

Resident Name STRING BEAN Medical Record No. 1101

ADL Score = _____ ADL Score = _____

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
BB	*Betty Bones, RN*	LB	*Letty Bones, LPN*	NB	*Nettie Bones, CNA*	TS	*Ted Skeleton*

Example # 11 Rationale: _____

Self-Performance Key	Support Provided Key
0 =Independent--No help or oversight 1 =Supervision—Oversight, encouragement or cueing provided 2 =Limited Assistance—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 =Extensive Assistance--Resident performed part of activity but help of the following type(s) were provided *Weight-bearing support *Full staff performance 4 =Total Dependence--Full staff performance of activity during entire shift 8 =Activity Did Not Occur on this shift *The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.*	0 =No setup or physical help from staff 1 =Setup help only 2 =One person physical assist 3 =Two+ persons physical assist 8 =Activity did not occur *The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.*

N=Nights D=Day E=Evenings

		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		A3a	
Date		9/15/04		9/16/04		9/17/04		9/18/04		9/19/04		9/20/04		9/21/04	
Bed Mobility – How resident moves to and from lying position, turns side to side, and positions body while in bed.															
			Int		Int		Int		Int		Int		Int		Int
Self Perform	6A	0	LB	4	BB	0	BB	0	BB	0	LB	0	LB	0	LB
	6P	0	NB	0	NB	0	NB	3	TS	0	TS	0	TS	0	NB
Support Provided	6A	0		0		0		0		0		0		0	
	6P	0		2		0		2		0		0		0	

Likely Transmitted Value _____ Review Value _____

Resident Name GREEN BEAN Medical Record No. 1201

ADL Score = ADL Score =

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
BB	*Betty Bones, RN*	TS	*Ted Skeleton*	LB	*Letty Bones, LPN*	NB	*Nettie Bones, CNA*

Example # 12 *Rationale:* _____

Case Mix Review

State of Louisiana
Department of Health and Hospitals
Medicaid Case Mix Review Verification Process
Project Overview

Case Mix Review Program Timeline

- Timeline for case mix verification process
  - 01/01/2005 to 06/30/2005
  - 07/01/2005 to 06/30/2006
  - 07/01/2006 to 06/30/2007

Policy Decisions for Case Mix Verification Reviews

- Delinquent MDS Assessment Definition
  - Any assessment with an R2b date greater than 121 days from the previous R2b date will be deemed delinquent and assigned a RUG-III code of BC1
- Case Mix Supportive Documentation Guidelines
  - Guidelines that define the supporting documentation necessary at the case mix review to verify a RUG-III MDS item
- Unsupported MDS Assessment Definition
  - When the case mix verification review results in a new RUG-III classification
- Frequency of Case Mix Reviews
  - Currently 50% of all Medicaid certified facilities are selected for review annually
- Sample Payer Source Selection
  - All payer types
- Primary Sample Size

  The greater of:
  - 20% of the residents listed on the final CMI report
  - 10 assessments
- Expanded Sample Size (required if primary sample is greater than 25% unsupported)

  The greater of:
  - 20% of the residents listed on the final CMI report
  - 10 assessments
- Required ADL documentation to reflect the observation period 24/7
  - ADL grid
  - ADL narrative
  - Any combination
- Threshold Defines When Corrective Action is Applied
  - Greater than 40% unsupported (01/01/2005 to 06/30/2005)
  - Greater than 35% unsupported (07/01/2005 to 06/30/2006)
  - Greater than 25% unsupported (07/01/2006 and beyond)

- Phase In Corrective Action
  - ReRUG all unsupported assessments when the facility exceeds the State threshold beginning 01/01/2005
- Follow-up Review Process
  - The Department reserves the right to conduct a follow-up review as needed but not earlier than 120 days following the exit date of the prior case mix review
  - The Case Mix Documentation Improvement Plan (DIP) may be required by DHH after the follow-up review and submitted to DHH on the designated due date
  - The DIP will serve to guide the next review process at the facility and determine if corrections have been implemented

On-site Review Protocol

- Facility Notification will occur no less than two (2) business days prior to the expected on-site review
  - First by phone
  - Second by fax
- Entrance conference provided prior to the beginning of the case mix review
  - Recommend facility Administrator, MDS coordinator and any other staff of facility choice
  - Reviewers will explain process and identify facility liaison
  - Reviewers will identify chart order and specific documentation needs
- Review process
  - Facility liaison will be provided a list of resident chart documentation needed
  - Reviewers will only request a portion of total documentation needs to minimize chart removal from the resident chart location
  - Reviewers will request the liaison to supply any documentation they are unable to locate in the medical chart
  - ***Facilities are NOT requested nor required to collate supporting documentation for the RN reviewers***
- Exit conference provided following the completion of the case mix review
  - Exit conference is an educational, learning experience
  - Facility Administrator or designee may invite any staff deemed appropriate to attend the exit conference
  - Reviewers will report the findings including the number of assessments reviewed sorted by RUG-III category and % unsupported
  - No supporting documentation may be submitted after the close of the exit conference

Post Review Protocol

- Facility will receive a post review letter no later than 10 business days following the exit conference date
- For facilities that exceed the State threshold, a Post CMI Review roster will be sent with post review letter

- Facility has 15 business days from receipt of the post review letter to request an informal reconsideration
- DHH response to the informal reconsideration no later than 10 business days following the receipt of the request for an informal reconsideration
- Facility has 30 business days following receipt of decision from DHH regarding the request for informal reconsideration to appeal findings
- No appeal will be considered unless the facility has exercised the informal reconsideration process

State of Louisiana
Department of Health and Hospitals
Post Review Timeline Sample

Requirement	Timing	Example
Exit Conference	Any date	03/01/2005
10-Day Summary Letter	Must be submitted to the facility no later than10 business days following the exit conference	03/15/2005
Informal Reconsideration	A formal request to DHH no later than 15 business days following receipt of the 10-day summary letter	04/05/2005
DHH Response to the Informal Reconsideration	A decision from DHH regarding the facility's request for reconsideration of a review matter no later than 10 business days following the receipt of the request for an informal reconsideration	04/19/2005
Appeal Process	No later than 30 business days following receipt of the decision from DHH regarding the request for the informal reconsideration ***Note: No appeal will be considered unless the facility has exercised the informal reconsideration process***	05/31/2005
Repeat Review	No sooner than 120 calendar days following the exit conference date	06/29/2005

State of Louisiana
Department of Health and Hospitals
Medicaid Case Mix Review and Rate Timeline

MDS Review Period	*MDS assessments complete with an R2b date on or before the point in time date provided on the CMI Report*	*Rate for Quarter*
January February March	***(CMI Report dated 10-01-year)*** July, August, September Assessments	January February March
April May June	***(CMI Report dated 01-01-year)*** October, November, December Assessments	April May June
July August September	***(CMI Report dated 04-01-year)*** January, February, March Assessments	July August September
October November December	***(CMI Report dated 07-01-year)*** April, May, June Assessments	October November December

State of Louisiana
Department of Health and Hospitals
Medicaid Case Mix Documentation Improvement Plan (DIP)
Procedure

The Case Mix Documentation Improvement Plan (DIP) may be required by DHH after the follow-up facility Medicaid Case Mix medical record review and submitted to DHH on the designated due date. The purpose of the DIP is to establish an expected implementation timeline for corrective action and ensure future compliance with the documentation guidelines.

The DIP is required to be completed and submitted to DHH no later than 15 business days from receipt of the case mix review findings letter. The DIP will identify areas of concern noted during the previous review. The facility is responsible for submitting a plan for compliance and providing an implementation date for the plan.

The DIP will serve to guide the next review process at the facility and determine if corrections have been implemented.

State of Louisiana
Department of Health and Hospitals
Medicaid Case Mix Documentation Improvement Plan (DIP)

Facility Name
Facility Address

Date of Exit Conference _____ **% Unsupported _____**
DIP Response Due Date _____

Date	*Areas of Concern*	*Documentation Improvement Plan*	*Implementation Date*	*Signature*

Administrator's Signature_____ **Date_____**

Resources

State of Louisiana
Department of Health and Hospitals
A Quick List of Louisiana Help Desks

Several different parties assist the assessment transmission and validation process. Myers and Stauffer LC is responsible for the Medicaid Rate Setting Process, associated assessment data and any report that bears the name of Louisiana Department of Health and Hospitals, Rate and Audit Review. We have detailed the major breakdown of each party's responsibilities below, however, you may call us initially if you are unsure of whom to contact and we will assist you in finding an answer to your question or direct you to the appropriate desk.

Medicaid Case Mix RN Reviewer
Questions concerning Medicaid Case Mix Reviews
Ruby Pecot (225) 342-6158

Myers and Stauffer LC (800) 763-2278 or (317) 816-4124
All questions related to Medicaid RUG-III classification calculations, preliminary or final resident listings report or Medicaid Case Mix Review.
Myers and Stauffer LC (800) 374-6858 or (816) 968-1977
All questions related to the provider rate.

Louisiana MDS Help Line (800) 261-1318
Questions related to the definition, completion or interpretation of the MDS 2.0 Resident Assessment Instrument. This line provided by Department of Health and Hospitals, Health Standards Section. Evelyn Enclarde, RN, State RAI/MDS Coordinator responds to these calls.

Medicare Date Communication Network (MDCN) Helpdesk (800) 905-2069
* Connection problems to MDCN (Medicare data Communication Network)
* MDCN ID's and passwords

Unisys - Provider Relations (800) 473-2783 or (225) 924-5040
Unisys - Provider Enrollment (225) 923-8510
Unisys - Long Term Care Unit - (225) 237-3259

REVS (800) 776-6323 or Telephonic Automated (225) 216-7387
Recipient Eligibility Verification System

DHH Regional Office (800) 834-3333
Providers contact for eligibility issues. Providers may also contact the appropriate DHH Parish Office for eligibility issues.

Raven Help Desk (800) 339-9313
Questions about the RAVEN software

MDS WEB ADDRESSES TO EXPLORE FOR INFORMATION AND RESOURCES

CMS MDS 2.0 Information- MDS Q&A
http://cms.hhs.gov/medicaid/mds20/default.asp
http://cms.hhs.gov/medicaid/mds20/whatsnew.asp

Correction Policy
http://www.cms.hhs.gov/medicaid/mds20/rai1202ch5.pdf
This is Chapter 5 in the new RAI Manual 2002

Federal Register- Listing of all the proposed federal laws
http://www.gpo.access.gov/fr/

Louisiana Department of Health and Hospitals
Evelyn Enclarde, RN, RAI Coordinator (Health Standards)
http://www.dhh.louisiana.gov/offices/?ID=112

Louisiana Department of Health and Hospitals
Ruby Pecot, RN, Medicaid Case Mix RN Reviewer (Rate and Audit)
http://www.dhh.louisiana.gov/rar

MDCN software (AT&T Global) –
http://www.attbusiness.net/softctr/software.html
http://www.cms.hhs.gov/mdcn/default.asp

MDS RAI Manual 2002 and Updates
http://www.cms.hhs.gov/medicaid/mds20/man-form.asp

MDS Software and forms on the CMS site
http://cms.hhs.gov/medicaid/mds20/man-form.asp

Medicare Information- Information the public can use to evaluate a nursing facility
http://www.medicare.gov/nhcompare/home.asp

Privacy Act information
http://aspe.os.dhhs.gov/admnsimp/

RAVEN software- Allows entry of MDS information and creation of files for submission to CMS
http://cms.hhs.gov/medicaid/mds20/raven.asp

Department of Health and Hospitals

Louisiana Advisor

Current Information on Louisiana Case Mix Reimbursement Vol. 4, Issue 1 - March 2005

2005 Case Mix Review Process

The corrective action phase of the Medicaid Case Mix Documentation reviews began January 31, 2005. Approximately 50% of the facilities in the state will be selected and reviewed.

Pre-Review Procedure: Upon arrival at the facility, the review team will introduce themselves and present an introduction letter that will list the reviewer(s) by name. The lead RN reviewer will explain the purpose of the visit and invite the Administrator, DON, MDS coordinator and facility liaison to meet for a short Entrance Conference.

During the Entrance Conference, the lead RN reviewer will describe the Medicaid Case Mix documentation verification process, identify a facility liaison, describe the necessary documentation required and request the first set of resident medical records to be reviewed. After answering facility questions, the Medicaid Case Mix documentation verification process will begin.

Post-Review Procedure: Once the legal medical record documentation review is complete, the facility staff shall be invited to participate in an Exit Conference. The facility Administrator may invite any staff personnel deemed appropriate for the Exit Conference information. The purpose of the conference is to provide the facility with a summary of the preliminary review findings.

The lead RN will provide the facility with the number of assessments reviewed, including the total for each RUG-III category, explain the percent "Unsupported", provide individual assessment comments and notable trends observed in the facility and answer all questions possible. Signatures will be obtained from all participants and the lead RN will provide the facility with a copy of the Exit Conference form if desired.

The Exit Conference form will serve as a record of the preliminary review

(continued on page 2)

In This Issue

The *Louisiana Advisor* is a publication produced under contract with The Department of Health and Hospitals by Myers and Stauffer LC
9265 Counselors Row, Ste. 200
Indianapolis, IN 46240

The *Louisiana Advisor* is published to keep all interested parties current on Louisiana Case Mix Reimbursement. Its goal is to provide information on major issues, work groups, and upcoming activities. The articles presented here are only a synopsis of the topics and are not intended to present a complete analysis of the issues.

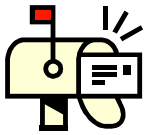
Documentation or Review Questions? Medicaid Case Mix RN Manager (225) 342-6158

MDS Clinical Questions? Health Standards (800) 261-1318

Medicaid CMI Report Questions? Myers and Stauffer (800) 763-2278

2005 Case Mix Review Process continued...

findings as well as topical educational issues discussed. At a minimum, this educational opportunity will address the areas in which the facility needs assistance with case mix documentation and review requirements. The Exit Conference will serve as the final opportunity for the staff to provide any further documentation to fully disclose the extent of services provided to the residents. Any documentation produced after the close of the Exit Conference will not be considered as supporting documentation per Rule LAC 50:VII.1313 (B2).



Within 10 business days following the exit conference date, the facility will receive a summary letter describing the results of the facility review statistics and any noted trends or documentation issues. If the review results in an unsupported percent greater than 40%, the unsupported assessments will be re-RUGged and a Post CMI Report will be sent with the summary letter. The unsupported records will be designated with an "R" in the note column of the Post CMI Report.

Informal Reconsideration: Upon receipt of the 10 business day summary letter, should the facility wish to exercise an informal reconsideration, a request from the facility to DHH must be received by DHH within 15 business days. The letter from the facility must describe, in detail, the facility's disagreement with the review findings. DHH will review the facility's informal dispute and must respond to the facility, by letter, within 10 business days.

Appeal Process: Should the facility continue to disagree, the facility has the right to request a formal appeal within 30 business days of receipt of the State's decision regarding the informal reconsideration.

Reminder: Per the MDS Verification Rule, any facility wishing to request an appeal must first exercise the informal reconsideration process. Should the facility not request an informal reconsideration, the formal appeal will be denied by the State.

Dear Cindy...

The "Dear Cindy..." column is a regular feature in each issue of *Louisiana Advisor*. Cindy Smith, Myers and Stauffer's RN consultant, will discuss questions that are frequently answered by our staff. We welcome your questions for future issues.

Dear Cindy:

Q. Do I need to modify records found to be unsupported at the Medicaid Case Mix review?

A. Only records with inaccurate information that meet the definition for significant correction or modification should be modified. Remember, an unsupported record means that the documentation found at the review resulted in a RUG-III classification change; it does not mean that the MDS was inaccurate.

For instructions on correcting errors in an MDS record that has been accepted into the state MDS database, refer to the RAI Manual, Pages 5-7 through 5-19.

Please submit your questions to the Myers and Stauffer Help Desk Staff 800-763-2278.

2004 Review Results

Medicaid Case Mix Documentation reviews for 2004 started on January 19th, 2004, and were completed on June 25th, 2004. Approximately 50% of the facilities in the state were reviewed. The facilities selected for review in 2004 had 20% of the residents reviewed as the primary MDS random assessment selection. An expanded review was required if the primary sample review resulted in greater than 25% unsupported. The expanded review included another 20% sample.

The state average unsupported percent for the 2004 reviews was 44%. This is an improvement over the previous year's average unsupported percent of 70%. The impaired cognition MDS items (B2a, B4, and C4) had the highest unsupported rate at 83.8%, followed by ADLs (G1aA, G1bA, G1hA, and G1iA) at 74.6%.

2005 Corrective Action Begins

The Medicaid Case Mix Reviews beginning 2005 may result in a corrective action to the facility. The following are the steps of the corrective action process:

Step 1 Primary sample of 20% or 10 assessments (whichever is greater) is reviewed. Should the percent unsupported be greater than 25%, an expanded review will occur. However, should the percent unsupported be 25% or less, the review ends and NO corrective action is applied.

Step 2 If the review is expanded, an expanded sample of 20% or 10 assessments (whichever is greater) is reviewed. Should the total percent unsupported be greater than the State threshold of 40%, all unsupported assessments will be re-Rugged. A new Post CMI Report will be processed that includes the new RUG-III codes for those unsupported assessments. A retro rate adjustment may be applied to the following quarter's rate.

Should the expanded review result in 40% or less unsupported, no unsupported assessments will be re-Rugged and **NO** corrective action applied.

Medical Record Documentation

You must **ALWAYS** code the MDS with an accurate picture of the resident, even if the documentation does not support this picture. This federal requirement to do so is noted at Section AA9 of the MDS and states:

"*I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.*"

Should the facility identify differences between what is documented and what is fact, the appropriate professional must make a legal medical notation in the medical record. MDS coding must, in all cases, reflect accuracy of the resident's facts. When facility documentation is inaccurate, the facility should take appropriate action to educate staff. **In no case should a facility code the MDS to reflect inaccurate medical documentation.**

LOUISIANA TIMELINE

2005

MARCH
- *Final CMI Report for 1/1/05*

MAY
- *Preliminary CMI Report for 4/1/05*
- *Training*

JUNE
- *Final CMI Report for 4/1/05*

Training, Training, Training

Training topics will include the following:

- **New, updated Supportive Documentation Guidelines**
- **Emphasis on CMI Report understanding**
- **Rate adjustment procedure**

Stay tuned for more details!!

LA Department of Health & Hospitals
BHSF Rate & Audit Review
P.O. Box 546
Baton Rouge, LA 70821-0546

ROUTE TO:

Administrator	_____
Director of Nursing	_____
MDS Coordinator	_____
Data Entry Personnel	_____
Consultants	_____
Other	_____

ATTENTION: MDS COORDINATOR